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The WISCONSIN MEDICAL JOURNAL

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A Monthly Journal of Medicine and Surgery

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VOLUME LIV

JANUARY 1955–DECEMBER 1955

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The Wisconsin Medical Journal, Official Publication
Advertising Representative: State Journal Advertising Bureau, 535 North Dearborn St., Chicago, Illinois

. . . . THE PRESIDENT'S PAGE . . . .

Law and Medicine Cooperate

MEDICO–LEGAL science comes down to us from great antiquity. Its early history is found in ancient criminal codes and records of court procedures. Medical knowledge was made use of very little in the legal procedures of the Greek and Roman eras. During the Middle Ages, however, it was utilized to a greater extent; but it was not until about the seventeenth century that the professions of law and medicine established any marked relationship. Since that time there has been an ever-increasing development in the science and in its varying phases.

Legal medicine is that branch of jurisprudence which deals with questions in law requiring technical knowledge of medical science. It is obvious that there are many of these and that sooner or later almost every practitioner of medicine is called upon to enter a court of law and give testimony.

While legal medicine, or medical jurisprudence, is taught in medical schools, it is well known that not much time is devoted to it, as is also the case with other problems of an economic and social nature encountered in medical practice. Medical education in its purely scientific aspects takes up about all the time available for teacher and student alike.

The physician entering practice, therefore, is quite unaware of many of his responsibilities in this direction. The Committee on Grievances has been aware of these problems for some time and has held many conferences with members of the legal profession regarding them. There have been two joint meetings with the representatives of the Wisconsin Bar Association. Out of these meetings and deliberations has come the Interprofessional Code, which was presented to the House of Delegates at the Annual Meeting last October.

It is not perfect; further conferences with the members of the Wisconsin Bar Association will have to be held regarding it. But the two professions of law and medicine have shown excellent cooperation and have worked together in a real attempt to develop something that will obviate the many misunderstandings that have existed in the past. Almost all of these can be prevented if an earnest, sincere attempt to solve them is made by both professions. The Wisconsin Bar Association and the State Medical Society are to be congratulated for their efforts.

Arthur J. McCary M.D.

JUN 7 1956

Your Partner—The State Medical Society

EVERY physician in Wisconsin profits from the activities of the State Medical Society of Wisconsin. The degree to which each physician benefits depends much upon his membership and his knowledge of how his Society operates. Every person in the state owes much to its existence. Yet, the public, like many physicians, is unaware of the scope and importance of the Society's work. This article is presented so that every physician may know how the Society benefits him and the public.

The State Medical Society of Wisconsin was created by an act of the Territorial Legislature in 1841, seven years before Wisconsin became a state. The Society is dedicated "to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life." The Society was organized in Madison by 13 physicians who attended its first meeting.

A nonprofit, public service organization, the Medical Society is democracy in its most effective form. Any reputable Doctor of Medicine may join his local county medical society. Wisconsin has 52 county medical societies whose members number nearly 3,200. Each of these county societies elects delegates to the House of Delegates of the State Medical Society—one delegate for each 50 full dues-paying members. The State Society House of Delegates, in turn, elects three delegates to the American Medical Association to represent Wisconsin doctors at the national level.

The delegates meet annually to determine the policies and program of the State Medical Society. Dues are established at this session. Between meetings, the Council has the full power and authority of the House of Delegates. It consists of the president, president-elect, past-president, speaker of the House of Delegates, treasurer, secretary, and 17 councilors. Each of the councilors serves one of the 13 medical districts into which the state has been divided.

The day-to-day affairs of the Society are supervised and coordinated by the secretary. A full-time staff of about 65 persons is required to carry out the activities authorized by the House of Delegates and Council. All of the Society's activities are currently housed in the Society's headquarters at 704 East Gorham Street, Madison. Because of expanding needs, the Society has purchased land on the south shore of Lake Monona in Madison at 314 East Lakeside Street. A new office building is being constructed there and is expected to be ready for occupancy about July 1, 1955. Society members are invited to visit the State Society office at any time.

Most State Medical Society activities are financed from membership dues, although many are largely self-supporting. For example, it costs about $25,000 a year to publish *The Wisconsin Medical Journal*, and all but about $4,000 is recovered from advertising. The Blue Shield Plan of Surgical-Medical Insurance is completely self-supporting in its administrative aspects. The total cost of the Annual Meeting is about $18,000 annually, and all but about $1,000 is recovered from the sale of exhibit space and luncheon tickets.

Architect's sketch of the new State Medical Society headquarters which will be located at 314 East Lakeside Street in Madison. It will house nearly 65 employees and all Society activities and agencies. Visitors are welcome.

The total annual budget of the Society is about $200,000. The Audit and Budget Committee makes a periodic and detailed study of the income and expenditures of the Society every year with a view to assuring the profession that it's "getting its money's worth" for its dues and that Society funds are being spent legally and appropriately. A complete and simplified explanation of the Society's annual budget is printed in *The Wisconsin Medical Journal* in either the May or June issue.

The Council meets from four to six times a year and its members are in constant contact with the Society office. Each of the 38 committees of the Society meets an average of four times a year to deal with the many and complex problems placed before it. Since councilors, officers, and committeemen serve without pay, acceptance of such positions means substantial personal sacrifice of time and money.

BENEFITS FOR THE PHYSICIAN

A Better Education

Medical education in Wisconsin is better because of the State Medical Society. The University of Wisconsin Medical School owes its existence, in part, to the Society's early efforts to bring a professional school to the campus. The Committee on Medical Education and Hospitals works with the deans at both Marquette and Wisconsin to improve curricula, to make the best possible use of clinical material, and to develop the preceptor programs. The Society helps the American Medical Education Foundation of the AMA to raise money from the medical profession to support medical schools. Schools may use the money in whatever way they wish—for faculty, buildings, research, and the like. In addition, the State Medical Society has established a Student Loan Fund to help needy and deserving medical students get through school. The Fund hopes to raise $250,000. It already has about $15,000 and has made six loans to date. Through the legislature, the Society works to increase facilities for the output of doctors. In the 1953 session the Society helped secure passage of a measure providing $1,400,000 for new medical buildings at the University of Wisconsin.

A Place to Practice

Whenever a doctor is looking for a place to practice—whether he is just out of school or seeking a change—his best bet is the Society's physician location service. This service keeps complete, up-to-date files on communities wanting physicians and physicians seeking locations. For the asking, a physician can get a full list of opportunities for full-time individual practice, locum tenens positions, and partnership or association. The Society cooperates with the American Medical Association's placement service to give physicians first-hand information on a national basis. Arrangements have been made with the armed forces to provide the military physician with full details about Wisconsin locations for practice prior to his release from service.

Postgraduate Education

The Council on Scientific Work is the nerve center of the Society's scientific affairs. It plans the scientific sessions of the Annual Meeting and a variety of local or regional meetings. Through it the Society provides an annual three-day scientific session including general and specialty lectures, demonstrations, "wet clinics," motion pictures, and scientific and technical exhibits.

In addition, nearly 20 individual teaching programs are organized in monthly circuits through the state to provide physicians with unusual opportunities for scientific training without undue absence from their practices. In single afternoon programs, repeated at various locations, doctors may hear outstanding medical teachers brought to Wisconsin from the nation's medical centers.

Special scientific sessions on cancer, psychiatric problems, and the like are arranged from time to time in different areas of the state. Government and voluntary agencies cooperate in these programs. These meetings are brought to the membership at a cost of less than 50 cents per member. This is possible because of the cooperation of the State Board of Health, the Wisconsin Heart Association, the Wisconsin Division of the American Cancer Society, Wisconsin's two medical schools, the Wisconsin Academy of General Practice, and the Wisconsin Anti-Tuberculosis Association.

Postgraduate education for physicians includes the Annual Meeting and at least 20 separate teaching clinics throughout each year.

Journal Keeps Doctors Informed

Every month *The Wisconsin Medical Journal* goes to nearly 3,500 physicians. It goes to every member of the State Medical Society. Others subscribe individually. The *Journal* is a constant source of postgraduate education for both the general practitioner and the specialist. It stimulates Wisconsin physicians to investigate clinical problems and publish their observations. With about 100 pages in each monthly issue, approximately 30 are assigned to scientific reading matter, 30 to organizational material, and the remainder to advertising. It contains editorials, a unique green sheet section on medical economics and public relations, and special sections from agencies and interests concerned with medicine and public health. The *Journal*, in its 94th year, is under the direction of the Council on Scientific Work, a medical editor, an editorial board, and an advertising committee.

Medicine's "Blue Book"

Each year the January issue of *The Wisconsin Medical Journal* is devoted to matters that will serve as a guide for practitioners in their personal and professional affairs with patients, courts, social and governmental agencies, and the community. There isn't a physician in the state who can't profit from the contents of this issue—making a

will, testifying in court, malpractice, services of state and voluntary health agencies, adoption procedures, medical partnerships, medical ethics, medical licensing laws, licensing of limited practitioners, agreements of lease, fee splitting, selling a practice, collection of accounts, narcotics laws, hospital records, and the like.

Questions About Medical Products and Devices

Whenever a physician has questions about drugs, diagnostic and therapeutic devices, and other products used in the practice of medicine, he should feel free to write to the State Medical Society. Hundreds of such requests are answered each year. Most of these products and devices are evaluated or tested by the American Medical Association. The doctor may contact the AMA directly or ask the State Society to help.

Cancer Detection and Control

Early detection is one of the secrets of cancer control. For the public this means knowing how to recognize the symptoms, when to see the doctor, and what to expect of him. For the doctor this means knowing and utilizing the best methods of detection and treatment. Both interests are served by the State Medical Society. Its Committee on Cancer serves as the medical and scientific committee of the Wisconsin Division of the American Cancer Society. It develops professional education projects in cancer throughout the state, influences the training of technicians in cancer detection and control, and produces public education leaflets. One example is "What You Can Expect of a Cancer Examination," a small but effective pamphlet of which over 500,000 copies have already been distributed through doctors' offices and other avenues. The Society does everything possible to impress the public with the fact that the private practitioner is trained to serve as a "cancer detection center."

Blood Bank Problems

Advice to doctors in handling blood bank problems is provided through the Committee on Blood Banks. It helped develop the gamma globulin polio prevention program in Wisconsin. It evaluates blood procurement policies, helps develop adequate medical supervision of civilian and military procurement, and serves as a review board for any hospital or doctor having a complaint about any blood bank program.

The Doctor and the Hospital

Sometimes it isn't easy for the doctor to find a proper and suitable financial and contractual relationship between himself and a hospital, particularly in the fields of pathology, radiology, anesthesiology, or physiatry. That's where the State Medical Society can help. Through the Committee on Hospital Relations and the staff, specific complaints from physicians or hospitals can be adjudicated; sometimes situations can be resolved before they become problems. Furthermore, this committee has conducted surveys to determine what, when, where, and how radiology and pathology services can be made available either part time or full time in communities throughout the state.

"Problems of State Medicine"

One of the purposes of the Medical Society as defined in 1841 is to deal effectively with "problems of state medicine." The founders of the Society could hardly have foreseen the extent and complexity of governmental and private agency activities in the field of public health and medicine. Today a significant portion of the State Medical Society's effort is directed to work with the state departments and voluntary agencies. The very nature and scope of public health problems today makes it imperative that the State Medical Society assume for the physician—and the public—many of the roles which in an earlier era were performed by the individual physician. In caring for his own patients, the physician can and must act as he always has. But sheer size and complexity often dwarf individual effort and demand coordinated action for effectiveness in broad public health matters. It is here that the State Medical Society performs a great service for the profession and public through the Commission on State Departments and its nine divisions:

. . . On Crippled Children

Orthopedic clinics have been developed throughout the state in cooperation with the Bureau of Handicapped Children of the State Department of Public Instruction. These have improved the effectiveness of proper diagnostic services available to family physicians and their patients. Outpatient services have been developed for rheumatic fever victims. A basic outline for the development of a rheumatic fever program has been prepared for county medical societies. Study is given to special clinics for the cerebral palsied, the epileptic, and children with cleft palate.

. . . On Geriatrics

Many state and voluntary agencies are concerned about the growing number of "old people" and their problems. The State Medical Society is trying to coordinate and guide these groups in their thinking on how to handle medical service, nutritional needs, and economic problems of the aged. It is preparing a guide for county medical societies concerned with developing homes and other facilities for the aged. It is working on how best to extend public welfare services to the aged at minimum cost. It seeks to coordinate public information about problems of "growing old."

The activities of some 38 Councils and Committees fill the calendar with meeting dates the year around.

. . . On Maternal and Child Welfare

Never before has the Wisconsin physician had such opportunity to benefit from clinical scientific studies on a significant patient problem—maternal mortality and fetal and neonatal deaths. In cooperation with the State Board of Health, the State Medical Society is making a comprehensive analysis of each maternal death. Through the cooperation of selected hospitals with pathologic service and the active participation of the Wisconsin Society of Pathologists, a series of pilot studies is being conducted in the fields of fetal and neonatal mortality. The facts, along with helpful advice, are given to the doctor and the hospital, with complete anonymity for all. This is medical education at its finest. It is true public service. Through this phase of Society activity, physicians and hospitals also receive advice on the handling of prematures, hospital policies for obstetric patients, and collection of adequate data on death and birth certificates.

. . . On Nervous and Mental Diseases

This is a problem loaded with public interest and opportunity for improvement. The State Medical Society advises the State Board of Health, the Department of Public Welfare, and the state legislature concerning personnel needs in the field of psychiatry, adequate medical supervision for mental health programs, provision of adequate facilities for state institutions, and more adequate medical examinations and general health care in county mental institutions. A special committee is reviewing existing statutes concerning medical aspects of court examinations and the apprehension and disposition of persons suffering from emotional disturbances. Other committees work on the care of emotionally disturbed children and means of remedying the shortage of trained psychiatric workers.

. . . On Public Assistance

The physician and his method of caring for the indigent patient may be significantly affected by various trends and developments in public assistance policies of government at the local, state, and federal levels. The State Medical Society seeks to serve the best interests of both physician and patient by its contacts with government in the fields of poor relief, categorical aids, and the general administrative problems. Studies are made of county fee schedules, the effect of health insurance in this field, and the implications of treatment authorization procedures and limitations.

. . . On Rehabilitation

Rehabilitation is rapidly gaining medical stature. By working closely with the Rehabilitation Division of the State Board of Vocational and Adult Education, the Medical Society assists in the development of adequate fee schedules for rehabilitation services. Educational programs in rehabilitation are held for the physician. The Society also helps the physician learn how, when, and where he can obtain rehabilitation services for his patients.

. . . On School Health

Effective school health programs need careful medical guidance. The State Medical Society provides or stimulates this direction through conferences between physicians and school people and the development of recognized standards and guides for good school health programs. This is done in cooperation with the State Board of Health, the Department of Public Instruction, and the Wisconsin Cooperative School Health Council. The physician is aided, too, by the Society's influence on proper policies for conduct of competitive sports in elementary and junior high schools and the establishment of sound medical regulations for the Wisconsin Interscholastic Athletic Association sports and insurance program.

. . . On Tuberculosis and Chest Diseases

Educational material for the physician to help him provide more intensive follow-up of suspected cases of tuberculosis is one aspect of the Society's effort in this field. The Society advises the State Board of Health and the Wisconsin Anti-Tuberculosis Association with regard to consultation services to county sanatoria, examination of teachers and other school employees, development of adequate legislation for free care of the tuberculous, and the like.

. . . On Visual and Hearing Defects

A special guide has been developed by the Society to help physicians and others establish vision testing programs in Wisconsin. The Bureau of Handicapped Children of the State Department of Public Instruction, as well as other agencies, has the Society's advice and guidance in this field. The Society enlists the aid of physicians for follow-through on cases in which hearing deficiencies are detected and studied at otologic clinics. Professional and executive education is furthered by a series of industrial

hearing meetings which explore medical implications of noise exposure, its relation to compensation claims, and similar problems. To assist industry in the development of a hearing conservation program, a guide has been prepared to provide for wide participation by physicians trained to render this service. Physicians may request information on the use of state services for patients suffering serious vision loss.

Admissions to Wisconsin General Hospital

The Society has played an important role in the development of policies governing the admission of private-pay and special patients to Wisconsin General Hospital at the University of Wisconsin. A Committee on Coordination of Medical Services continues to evaluate these policies with emphasis on their effect on the teaching of medical students and the ability of the hospital to serve the public.

SMS Promotes Good Health Insurance

For nearly 20 years the State Medical Society has been influential in developing high quality programs to help people provide insurance protection for the costs of medical and surgical care. The Society's efforts are tremendously important to both physician and patient. Today a Commission on Prepaid Plans, made up of 17 member physicians from all parts of the state, directs all health insurance activities.

The Society owns and operates Wisconsin Physicians Service ("The Doctor's Plan"), the Blue Shield Plan of the State Medical Society. Its activities and employees are housed at the Medical Society headquarters. It provides insurance protection for doctors' services to nearly 300,000 persons in Wisconsin. During 1954 this plan provided payments of nearly $3,500,000 to Wisconsin physicians for their services to patients.

The Society also sponsors and approves The Wisconsin Plan, a program of medical-surgical protection sold through private insurance companies. The Medical Society sets up the minimum requirements under which the insurance companies may sell this plan. While this idea was unique with Wisconsin, eight or ten other states have since adopted it.

Both of these prepaid plans operate under identical fee schedules carefully worked out by the Society. In Blue Shield, all claims are administered by the Medical Society staff or committees of physicians. In The Wisconsin Plan, claim disputes are handled by the Medical Society. Undoubtedly, the prepaid plans have been a stabilizing influence on physicians' incomes. They are a boon to the public because they provide a device for economical financing of major health care costs while preserving the patient's free choice of physician.

The Doctor's Partner in Veterans' Claims

The State Medical Society serves as the physician's partner in dealing with the Veterans Administration on claims for care provided to veterans

IBM equipment is used to keep membership records, pay Blue Shield claims, and conduct surveys on various subjects.

with service-connected disabilities. Since 1947, the VA has contracted with the Society to make it possible for certain veterans to have the services of their personal, home-town physicians at government expense. The Society relieves the doctor of much detailed bookwork and correspondence with the VA. It goes to bat for the doctor and the veteran on justifiable claims. Through the Veterans Medical Service Agency of the Medical Society, over 100,000 claims have been handled for Wisconsin doctors since 1947. The total dollar value of these claims has been over $1,500,000. It is a successful demonstration of the profession's ability to maintain the doctor-patient relationship while helping Congress carry out its promise of adequate medical care for eligible veterans.

Helping the Doctor in Industrial Cases

Through what is called the "Open Panel" program, the Society assures Wisconsin employees the privilege of choosing their own personal physicians for the care of industrial injuries. This has obvious advantages to doctors and employees. Annually the Society prepares and distributes to employers nearly 60,000 copies of "panels" of physicians in each county who wish to engage in the treatment of industrial cases. In addition, the Society adjudicates differences between insurance carriers, employers, and physicians participating in the program.

Society Represents Doctors in Legislation

One of the important services which the State Medical Society performs for physicians is that of representing the medical profession before the state legislature and Congress. The Society sees its duty to offer lawmakers facts about the health sciences, evaluation of health problems, and recommendations on translating new medical knowledge and developments into laws for improving and safeguarding the people's health. The Society's Committee on Public Policy and staff conduct long and

detailed investigations into significant public health problems between sessions in order to present the legislature with the profession's best judgment for their solution. Every one of the thousand or more bills introduced in each session of the state legislature is carefully scrutinized. Committee members, staff, and legal counsel collect evidence, arrange appearances, and testify before legislative committees. Examples of the Society's efforts are apparent in the establishment of the State Board of Health, medical licensing laws, the University of Wisconsin Medical School, regulations permitting operation of voluntary prepaid health insurance plans, laws protecting the public from quackery and cultism, and the like.

The Public Policy Committee advises the Council and the House of Delegates on the position the Society should take on legislation. Its actions are subject to Council and House approval and must be taken within the framework of policy laid down by them. The entire membership of the Society is kept advised of the general content of all legislation and special efforts are made to inform county officers. The suggestions and advice of any member are welcomed at all times.

Group Disability Program for Physicians

Of direct and personal benefit to a member of the State Medical Society is his eligibility to enroll in the Society's group accident, sickness, and hospitalization insurance program. Write for information. Benefits paid to insured physicians by the plan's underwriter, the Provident Life and Accident Insurance Company, total over $600,000 after four years of operation. Claims for disability benefits have been settled promptly and equitably. Disputes between a physician and the insurance company are investigated by the Society.

The insurance is available to members of the Society in the active practice of medicine who are less than 70 years of age. Benefits for insured members are available through age 74. Eligible members may obtain the protection without submitting the usual health questionnaire, providing their application is made when they become eligible. New members of the Society who are under age 32 may apply within one year and the members over 32 within six months without consideration of present physical condition or past medical history. The policy is non-cancellable to age 75 provided the physician is an actively practicing member of the Society. See page 40 for details.

Going Into Military Service?

Virtually every able-bodied physician in Wisconsin is subject to military service at some point in his professional career. The Committee on Military Medical Service and the staff—often in direct contact with officials of the armed forces—provide information and advice to any physicians faced with this interruption of civilian practice. Through the committee, recommendations are made to Selective Service and the reserve branches of the armed forces concerning the availability of physicians for active duty. Its primary purpose is to protect civilian medical service interests while at the same time providing a contribution to national defense.

Records of All Physicians

A great deal of service is provided to Wisconsin physicians from the State Medical Society's files of detailed information about every physician in the state. This data, now kept manually on cards and in files, is being transferred to IBM cards. The records are invaluable in providing endorsements for reciprocity; adjudicating dues problems; handling subscriptions for the Journal of the AMA, its specialty journals, and *Today's Health;* providing information on the location of physicians, board-certified specialists, and qualifications of all physicians; identifying quacks who pose as M.D.'s; locating colleagues; determining the number and distribution of physicians; and aiding the equitable call-up of physicians in wartime. The membership department of the Society also handles all mechanical details of obtaining physician participation in the prepaid insurance plans, veterans' care program, physicians' disability plan, and the open panel program.

Records of every physician in Wisconsin are kept by the membership department. They are invaluable to doctors themselves and for many surveys.

Public Relations Aids

A wide variety of projects, programs, and tools developed by the State Medical Society and the American Medical Association are available through the Society office to help physicians in their public relations. Here are some:

Medical-Press Conferences—A series of conferences has been held around the state to help doctors and newsmen do a better job of working together to serve the public, each group in its own way. The Society is always ready to help individual physicians or county medical societies on problems with newspapers and radio or television stations.

Round-the-Clock Medical Service—The Society has made detailed studies of patterns of medical practice and how medical care is available throughout Wisconsin 24 hours every day. Still, some doctors need help in organizing effective emergency service plans. The Society advises the profession and the public on the best methods of meeting this situation.

Health Pamphlets—A wide variety of pamphlets on health and medical economic problems are available upon request of the Society. Many pamphlets are free. Quantity orders of some pamphlets are available at cost. Pamphlets may be used to bolster the physician's verbal orders to his patients, to educate patients to better health practices, and to create understanding of medicine's efforts to build a healthier world. Write the State Medical Society for a list of public relations pamphlets.

News Releases—Periodic news releases are issued from the Society office to keep the public informed of Society activities, to alert the people to special health problems, and to tell the story of medicine's progress.

Medicine on the Radio—One of the Society's most valuable public relations projects for physicians and the public is "The March of Medicine," a weekly radio program produced on tape by the Society and presented as a public service by 40 radio stations. This 15-minute program provides the public with sound health advice on common problems and urges listeners to "see your family doctor" regularly. It is estimated that at least 300,000 persons hear each of the 52 yearly broadcasts. In addition, the Society provides all Wisconsin radio stations with spot announcements on good health practices.

Health News for Industry—Hundreds of industrial nurses in Wisconsin were without adequately prepared "hints for good health" until the Society began providing monthly bulletins. Now industrial house organs, plant bulletin boards, and monthly pay envelopes in many plants carry Medical Society advice for healthier living.

First Aid Charts—Public ignorance of proper first aid has often contributed to injury or even death. Sometimes it hinders the physician in proper treatment. The State Medical Society is attempting to counteract this problem by publishing colorful, cartoonlike first aid charts providing information on common accidents and conditions. Over 50,000 have already been distributed.

Tape Recordings on Loan—High schools desiring to use selected "March of Medicine" programs for teaching purposes can obtain these tape recordings on a loan basis. Tapes are currently loaned at a rate of 100 per month.

Nurse Recruitment and Education—With an eye to doing something to relieve the registered and trained practical nurse problem, the Society is making an intensive study of education and recruitment of nurses in Wisconsin. It is hoped this will produce direct benefits to doctors, hospitals, and patients.

More Assistants for Physicians—The recruitment of personnel for careers in fields allied to medicine—nursing, medical technology, laboratory work, medical secretarial work, pharmacy, public health work, and the like—is encouraged through the distribution of recruitment literature and assistance to high schools planning career days for students.

Public Meetings—Speakers, films, exhibits, and pamphlets are provided for meetings sponsored by physicians, woman's auxiliary groups, or others on topics related to personal health or economic and social aspects of medicine. Loan packets are available on a wide variety of health subjects for meetings, students, and the like.

"Personal Service" to Physicians

While many of the Society's activities lend themselves to classification as projects and programs outlined previously, a tremendous amount of the Society's effort can be classified in no other way than as "personal service" to individual physicians. Day-to-day correspondence between members, the public, and the Society is responsible for much staff time and effort. Each of the inquiries presents a particular problem; and while some may be relatively routine, others require detailed study and research, conferences for a decision on means of expressing the Society's policy, and sometimes reference to appropriate committees or councils of the Society for final determination.

Medical-legal problems constitute a large proportion of such inquiries. Typical of these are requests for information on the legal aspects of medical testimony, sale and use of narcotics, access to hospital records, Workmen's Compensation Act and estimation of permanent disability, release of information about patients to the press, licensing, establishing and operating a practice, and an almost unlimited number of similar questions.

Building an office can be quite a problem for a physician. The Society has a collection of information about floor plans and "pointers" to keep in mind when constructing office facilities. The Society also

Incoming and outgoing mail is counted in the hundreds of thousands of pieces every year.

provides information on agreements of lease, the selling price of a medical practice, and arranging a partnership.

The Society also helps its member physicians by providing facts on business methods, insurance and financial problems, taxation, medical care costs, voluntary health insurance, government medical services, state and federal legislation, physician and hospital relations, medical education, hospitals and physician supply and distribution.

Service to the Public

Many of the projects outlined previously have obvious direct benefit for the public. Conferences, radio and TV shows, newspaper releases, pamphlets, answering letters, exposing quackery, assuring well-trained and constantly up-to-date physicians, proposing and supporting sound medical and health legislation, and cooperating with public groups in many health education projects are typical of the public service efforts of the State Medical Society.

Of special significance is the Committee on Grievances, which provides a facility to which the public may bring its problems, its complaints, and its "gripes" concerning an individual physician, physicians as a profession, or the medical care situation in a particular area. The Committee may consider as many as 100 matters during the course of a year, but that is not indicative of the total picture. Many are handled by county societies. The total yearly contacts between physicians and patients must be counted in the millions. In the physician's daily contact with the sick, he is necessarily confronted with emotional stress and deep personal concern, the perfect culture in which to breed possible misunderstanding and dissatisfaction. The Committee's work involves detailed and deliberate case study and interview, patience and painstaking investigation, soundly-considered advice, and even discipline of physicians of all ages and types of practice. Its activities may have a tremendous influence on patterns of practice and the status of doctor-patient relationships in general.

Considerable effort is expended by the Society in planning for the care of casualties in the event of natural or wartime disasters. The Committee on Civil Defense has prepared detailed instructions for physicians in the handling of emergency care of casualties and cooperates with the State Office of Civil Defense, county and city officials, and county medical societies in developing adequate programs to meet emergencies.

The Council on Medical Service has sponsored several state-wide health conferences dealing with rural health problems. It also provides direction of the health-safety program of the Wisconsin 4–H clubs and $200 in scholarships and awards for young people who are outstanding in their health achievements.

Woman's Auxiliary to the State Medical Society

The Auxiliary is serviced to a considerable extent from the office of the State Medical Society. Advice and assistance are available to it, its records are maintained in the Society's office, a bulletin is prepared and distributed in cooperation with the Auxiliary editorial board, and special activities of the Auxiliary are provided with mechanical implementations through the Society's facilities. Of special significance to the doctors and the public are the Auxiliary's efforts in nurse recruitment and scholarships, encouraging the distribution of *Today's Health*, and arranging public meetings at which Medical Society activities and major health problems may be discussed.

The History of Medicine

The accumulation and preservation of an adequate record of the development and progress of medicine in Wisconsin is a project assigned to the Society's Historical Committee. It seeks to preserve vital records, reports of activities and projects, and a wide variety of items reflecting the influence of the physician on public health. Its program receives the assistance of the State Historical Society and the Woman's Auxiliary to the State Medical Society.

The Physician's Role in the Society

The strength of the State Medical Society of Wisconsin lies in its members and their county medical societies. The individual member should first be a competent, understanding practitioner. Second, he should be an active, conscientious citizen and participant in Medical Society affairs. His vote in the county society is the first step toward an effective voice in state and national medical policies.

The physician himself can determine how much he "gets" from the State Medical Society by knowing how to benefit fully from its many services. The suggestions and ideas of every member are always sought and considered. A wealth of information is available from the State Medical Society for the asking. Every member is always welcome at the Society headquarters. Visit the office in Madison at the next opportunity. Attend county and state medical meetings. Participate in the scientific sessions, but don't forget to visit the House of Delegates at Annual Meeting time. Every member is welcome to exercise his right and privilege of appearing before any reference committee of the House.

Be ready to make a contribution to medical progress and the health of the people. Also be ready to defend the profession. Criticism is healthy when it is based on knowledge—a fact as true when it comes from within the profession as from without. The State Medical Society of Wisconsin belongs to the physicians of Wisconsin. It is theirs to direct, to use, and to serve.

Malpractice and the Physician*

By LOUIS J. REGAN, M. D., LL. B.

THE incidence of malpractice claims increased tenfold during the decade between 1930 and 1940. In some localities, malpractice claims have become so frequent that any patient with a less than perfect end result is a potential malpractice claimant. If this alarming situation were evidence that the medical profession was becoming increasingly inefficient, then the solution would of course be obvious. But the blunt truth is that the majority of all malpractice suits filed are without merit; more than half of them involve physicians who are above the median of their respective groups in skill, experience, and professional standing. The search for a solution to this problem demands an understanding of what actually constitutes malpractice, an analysis of the causes of malpractice claims, and a universal knowledge among physicians as to the positive steps which may be taken to decrease both the relatively few justified claims and the preponderantly greater number of unjustified claims.

Any Physician May Be Sued for Malpractice

The bringing of a malpractice action does not even suggest that the claim has merit; for any patient may bring such an action against any physician who has attended him professionally. Nevertheless, the practitioner who is the target of the accusation is damaged by the mere filing of the action. Accordingly, it is necessary that every physician understand what constitutes malpractice under the law.

What Constitutes Malpractice Under the Law?

The law requires that a physician who undertakes to diagnose or to treat a patient must possess the skill and exercise the care commonly possessed and exercised by other reputable physicians in the locality. If he holds himself out as a specialist, he must meet the standards of practice of the specialist in the designated field of practice. These legal interpretations of his duty are not changed if the professional services are rendered gratuitously. It follows, then, that no malpractice charge is justifiable unless the physician's service to the patient does not meet the requirements of good medical practice; unless in the diagnosis or treatment of his patient, the physician omits to do something he should do or does something he should not do in terms of accepted standards of practice. The standard of practice is always determined by what other reputable physicians in the community, or in similar communities, would or would not do in the care of similar cases.

This definition of standards needs further clarification; for medicine is not an exact science, and not all patients who are given medical treatment get well. Many are left with some disability or deformity. There are few conditions in which there is available a sole, specific, universally utilized remedy or procedure. There is frequently a great latitude for honest difference of opinion, and often the attending physician must exercise his best judgment in deciding which of the several methods to adopt. In certain circumstances, the physician's acts or omissions may be so unseemly and shocking as to be generally recognized as reprehensible and supportive of legal liability. On the other hand, complications or untoward and unexpected results are not uncommon, and the mere fact that a patient is not cured or does not progress favorably does not suggest culpable ignorance or negligence on the part of the medical attendant.

Under Law, What Skill and Care Has the Patient the Right to Expect?

In the absence of evidence to the contrary, the law presumes that a physician has exercised the ordinary skill and care required of him in treating his patient. He is justified if his conduct of the case would be approved by even a respectable minority of his confreres in the same locality. He may make a mistake in diagnosis or be guilty of an error of judgment; he may use medicines or methods of treatment different from those which some of his colleagues would have used; he may obtain a bad result instead of a satisfactory one; but no one of these things is sufficient to fasten upon him the charge of malpractice. Actionable malpractice consists in doing something that should not be done or in omitting to do something that should be done.

Malpractice Suits Lessen Public's Confidence in Medical Profession

It is of primary importance, of course, that every physician familiarize himself with his legal interpretation of what does and what does not constitute malpractice. But that is only the first part of the control of the malpractice contagion; for experience has taught us that the most meticulous attention to the dictates of good medical practice is not sufficient to ward off unjust claims and that no physician, regardless of his excellence, is immune. The misunderstanding, indeed the ill will, which has been engendered by the great number of unjust malpractice suits has tended to break down the public's confidence in the medical profession. This situation has

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* Reprinted, with permission, from the Journal of the American Medical Association, September 2, 1951. In a more recent, but less comprehensive article on the same subject, Doctor Regan says, "the situation continues to grow worse." See *The Journal of the American Medical Association*, December 4, 1954, page 1317, "Malpractice, an Occupational Hazard."

important and far-reaching implications for both the public and the medical profession; for the public interest is adversely affected when the physician in caring for his patient is forced to give thought, time, and energy to safeguarding himself against the possibility of an unjust malpractice claim. The public should be informed of the facts of this problem, for in the long run, it is the public—in the persons of individual patients—whose well being is being jeopardized. There is no relationship outside the family which is so personal and intimate as that of physician and patient, no relationship in which the character, integrity, and conscience of one party are so important to the well being of the other. The overwhelming majority of physicians faithfully and unselfishly meet the demands and obligations of their calling; and the majority of patients do not unjustly file malpractice suits. The acts of the ignorant, the greedy, the callous few—among either patients or physicians—must not be permitted to destroy the merited esteem in which the profession as a whole is held.

How Much Shall the Physician Tell His Patient?

As a basic step in improving the situation, the physician must realize that at all times he is obligated to act with the utmost good faith toward his patient. Thus, if he knows that he can not accomplish a cure or that the treatment adopted will probably be of no benefit, he is duty bound to advise his patient of these facts. It is extremely doubtful that a physician has a therapeutic privilege to withhold a specific diagnosis from a patient who is sick with serious or fatal illness. To the contrary, the confidential relationship requires in ordinary circumstances that the physician make a frank and full disclosure of all the pertinent facts to any adult and mentally competent patient. Such completely open handling of a case would do much to improve the physician-patient relationship and to remove the possibility of unjust malpractice actions. However, there are other unavoidable and even psychological factors in the practice of medicine which must also be considered carefully in this respect.

Factors That Promote Malpractice Suits

If physicians were always able to obtain perfect results there would be, of course, no malpractice actions. But deaths, untoward and unexpected results, continuing disabilities, and complications occur and will continue to occur. Whether or not the uncured patient brings an action is often determined by his feeling toward the physician. Patients who have a feeling of friendly trust for the physician and who believe that everything possible has been done for them are not so likely to sue for malpractice—even when bad results ensue. Malpractice suits more often arise if the patient is resentful of some fancied or actual affront, if he believes that he has not been sufficiently closely attended, or—above all—if some third person raises a doubt in his mind as to the propriety of the treatment. In regard to this last point, it would be sheer folly to assume that the "third person" is always—or even most often—a layman who is uninformed about the facts of the case. Regrettably, many of these people are physicians who are also uninformed about the details and facts but who precipitate unjustifiable suits by criticising directly or by implication the work of physicians who have cared for particular cases.

Another potential danger to the physician-patient relationship arises from the physician's lack of attention to certain elements of patient psychology as factors in malpractice causation. Although the patient is sick or injured when he comes to his physician, he nevertheless visualizes himself as he was prior to becoming sick—with his body structures intact. Thus, unless the physician understands this viewpoint and prepares the patient properly, the patient with a fracture, for example, is likely to compare the final result with the part prior to injury, not with the injured member as presented to the physician. As another example of patient psychology, the average patient is not disposed to understand an error in diagnosis or the failure to make an early diagnosis. Or again, the unwarned patient is not happy with the surface tissue changes which are some times associated with deep x-ray therapy.

An analysis of malpractice claims reveals the significant fact that they arise almost invariably out of the first course of treatment. In other words, it is rare indeed that an old patient instigates a suit against his physician. It is obvious, then, that from the very first contact—indeed, especially with the very first contact—the physician should do everything within his power to develop an honest, frank, and psychologically sound relationship with his patient.

How Physicians May Safeguard Themselves Against Malpractice Suits

The foregoing discussion has analyzed what malpractice is and what can be done in the physician's conduct to avoid real malpractice or to forestall the filing of an unjust claim. But it would be completely unrealistic to assume that any course of conduct on the part of the physician would prevent his being unjustly sued for malpractice. Good medical practice in itself is not enough; the physician must be able to defend his actions by proof of what he has done. He must not only know his legal duty to his patient, but he must fulfill it. He must know and take advantage of every measure to protect himself against the unjustified claim of malpractice. Under present circumstances, it is absolutely foolhardy for any physician to be ignorant of or careless of malpractice prophylaxis. He must take positive actions carefully based upon his legal responsibilities and liabilities.

To begin with, a physician is not legally obligated to undertake the care of any patient. But from the time he assumes the responsibility until he is discharged or withdraws from the case, he must give—or be sure that there is given—the care and treat-

ment required by the condition of the patient. Before a physician may, without legal liability, withdraw from a case he must give reasonable notice of his intention and allow the patient reasonable opportunity to fill his place.

By notice or special contract, the physician may limit the service he is to render. He may agree to treat the patient only at a certain place, or for a limited time, or for certain conditions. On the other hand, he may increase his obligation by expressly agreeing or warranting that he will effect a particular result; in this circumstance, he will be liable on his contract or warranty if he fails to fulfill the agreement. A physician is not an insurer of results unless he makes himself one by his special promise.

Many malpractice actions are brought as the result of some unwise statement made by the attending physician, or his partner, assistant, or office nurse, to the patient or to a friend of the patient. Care should be taken to avoid making any remark constituting an "admission" of fault, or one which may be construed as such. It is understandable that such remarks have been made under emotional stress or when exercising "hindsight" in the face of an unsatisfactory result even when good practice has been followed throughout. A single careless statement might create liability for damages where actually no liability exists. The effect of such a remark when reported to a jury is incalculable and almost impossible to counteract. Further, an admission on the part of the defendant may free the plaintiff from the necessity of offering medical expert testimony.

Expert Testimony and Res Ipsa Loquitur

Generally, the proof of a physician's negligence must be established by the testimony of medical expert witnesses. The application of the doctrine of *res ipsa loquitur*[1] in a case gives rise to an inference of negligence on the part of the defendant, and relieves the plaintiff of the necessity of proving the alleged malpractice by the testimony of experts. It places on the defendant the burden of making explanation, if he can, to offset the inference of negligence; and by the majority rule a question is created for the jury, regardless of any and all evidence presented by the defendant.

The doctrine of *res ipsa loquitur* has been held applicable in the field of malpractice chiefly in cases which involve (1) slipping instruments, (2) sponges left in the tissues, (3) burns from heating modalities, (4) roentgen radiation injuries, generally limited to cases wherein the roentgen ray is being used diagnostically, (5) infection through the use of an unsterilized needle or instrument, and (6) injury to a portion of an anesthetized patient's body outside the field of treatment or operation.

[1] *Res ipsa loquitur* (literally, the thing speaks for itself) is a doctrine of the general law of negligence. It is held applicable whenever one person is injured by an instrumentality entirely in the control of another person, the use of which does not ordinarily result in injury if the person in control exercises due care.

A Good Case Record is a Valuable Safeguard

The importance of good medical case records, as a factor in malpractice prophylaxis can not be overestimated. A good medical case record should contain a history[2] of the case and a physical examination of the patient, together with reports of all indicated laboratory studies. These data constitute the foundation of the medical record and will generally serve as the basis for at least a working diagnosis. If diagnosis is not possible, consultation is desirable. Consultation reports must be in writing. Thereafter, a good record will reflect (by means of progress notes) a sequential history of the case, its course, complications, and sequelae and, thus, the justification for further or changed investigation and treatment. Such a record will contain a statement of all treatment rendered in the case. Copies of special forms and of reports used or made in a particular case are also a part of a good record. It is desirable that an attending physician ask himself from time to time what he would wish to have in the record of the case under treatment in the event he should later be called upon to justify in court his conduct of the case. If a patient discontinues treatment before he should or fails to follow instructions, the record should show it. A good method is to file a carbon copy of the letter sent to the patient advising him against the unwise course.[3]

Unwarranted Professional Criticisms Promote Malpractice Suits

The precipitating cause of a majority of all malpractice actions is found in the unwise comments or criticism of physicians with regard to treatment given to patients by other physicians. Commonly it is criticism by a succeeding physician of the work of his predecessor. Various authorities have estimated that 50 to 80 per cent of all the suits for malpractice would be eliminated if such destructive criticism could be stopped. It is profitless to attempt to determine why physicians are so prone to criticise destructively and unethically, but the results of it are deplorable. Legitimate criticism rests only on full knowledge of the facts as gathered from all parties; from the physician who treated the patient, as well as from the patient.

Other Preventive Precautions

The importance of tact can hardly be overemphasized. It should be manifest especially in the handling of the patient and the patient's family; in the avoidance of fee disputes and unwise efforts and methods in the collection of fees (considering the provisions of the statute of limitations); in the avoidance of overoptimistic prognoses and especially of any promise constituting a guarantee of a par-

[2] It is important to indicate the source of the medical history (from the patient, member of family, etc.).

[3] There is a legal presumption that a letter mailed has been received by the addressee; but there is no presumption that a letter has been mailed.

ticular result; in the avoidance of betrayal of privileged communications; in the avoidance of making any statement constituting (or which might be construed as) an "admission" of fault or negligence; in the avoidance of any reference to malpractice insurance protection; and in the securing of legal advice before making any statement in regard to a malpractice claim or suit.

Liability for Acts of Others

In addition to being responsible for his own acts and omissions, a physician encounters, in his everyday practice, instances in which he may also be responsible for the negligent acts and omissions of others. Thus, he is responsible for the acts of his assistants and employees, for their negligence occurring during the course of their employment. Where doctors practice as partners, each partner is liable not only for his own acts and those of his partner, but for the negligent acts of any agent or employee of the partnership.

When two independent practitioners are caring for a patient, each is liable not only for his own acts but for doing nothing about the negligent acts of the other which he has observed or which in the exercise of ordinary diligence he should have observed.

The attending physician is generally not liable for the negligence of an interne, a nurse, or other hospital employee. He is, however, responsible for the acts of the hospital personnel in so far as they are carried out under his immediate supervision and control. Thus, the operating surgeon and not the hospital is held liable for any negligence of operating room attendants during the performance of surgery.

Consent for Operations, Treatment and Autopsies

Consent for operation must always be secured. Any adult in a clear state of mind may authorize operation upon himself. Oral consent might be considered sufficient; but because of the difficulty in proving that it was given, the physician should invariably require a witnessed consent in writing. If the patient is a minor (that is, a person under the age of twenty-one) consent is to be obtained from parent or guardian.[4] If the individual is mentally incompetent, the consent of the one who stands in the position of guardian is required.

When an operation is made compulsory by law (such as vaccination or sterilization[5]) the law furnishes the consent. If an operation is unlawful, consent to the performance thereof does not absolve the surgeon from liability.

In an emergency which demands immediate action for the preservation of the life or health of a patient and in which it is not practicable to obtain his consent or the consent of any one authorized to speak for him, it is the duty of the attending physician to perform without consent such operation as good surgical practice demands.[6]

If sterility is likely to result from the surgery which is contemplated, explanation of that probability should be made and a signed authorization obtained from both spouses. It should be borne in mind that it is hazardous to sterilize any person except upon a positive medical indication. Further, there should be no promise or guarantee that the patient will be sterilized as the result of the procedure undertaken.

The individual physician must secure consent to perform a postmortem examination. This, too, should be in writing[7] and sufficiently comprehensive to allow the removal and taking away of tissue if such is to be done.

The trend of the cases in recent years indicates that it is extremely unwise to pursue a course of treatment in itself hazardous or capable of producing harmful effect without securing a written statement from the patient, or from someone legally responsible for the patient—a statement which clearly expresses understanding of and consent to the special treatment.

Failure to Use Recognized Diagnostic Aids

There are a large number of malpractice actions in the law reports which may be classified under the general heading of "Insufficient Treatment Cases." In every field of medical practice there are cases illustrating "insufficient care": the failure to make a blood count, a Wassermann, a pregnancy test, a culture, a smear, a urinalysis, a stool examination, an x-ray, original or follow-up; failure to make a complete diagnosis or overlooking a reasonably determinable condition; failure to utilize an indicated prophylactic measure (diphtheria, tetanus, etc.); the failure to give instructions, to follow up the original treatment or operation, to institute measures to protect contacts, etc., etc.

Failure to use the x-ray at all, or failure to make sufficient use of the x-ray, has been the chief allegation in many malpractice actions. Whenever a fracture is present which was not diagnosed and no x-rays were taken, the conduct of the attending physician is likely to be condemned as not coming within the standard of good practice.[8] Whenever a bad re-

[4] Statutory exception: In California a female of the age of 18 or more who is or has been married is an adult for the purpose of this consent.

[5] Under Eugenic Sterilization Statutes.

[6] 48 C. J. 1131; Jackovach v. Yocum (Iowa), 237 N. W. 444.

[7] In California, and several other states, it is criminally illegal for any person to perform an autopsy without having first obtained the written authorization of the coroner or other authorized public officer or of the person who has the right of disposition of the body.

[8] "The failure to make use of x-ray as an aid to diagnosis in cases of fracture amounts to a failure to use that degree of care and diligence ordinarily used by physicians of good standing in the community and the court, in absence of expert testimony, may take judicial notice of such fact." Agnew v. City of Los Angeles (Cal.) 218 Pac. (2d) 66.

sult, deformity or limitation of motion occurs, the defense is immeasurably strengthened by the possession of a series of x-rays taken at intervals during the progress of the case. Whenever a patient refuses to have an x-ray made, the physician should fortify himself with the strongest written evidence. X-ray records, as well as the entire case record, should be carefully preserved beyond the time during which a malpractice action may be brought.

The statute of limitations provides the period of time after which specified actions may not be brought. The time provided varies greatly in the several states. A physician should wisely inform himself of the situation in his own state.

Obligations to Patients

To summarize, the physician who would understand his legal obligations, responsibilities, and duties to his patient, must constantly bear in mind the following fundamental obligations:

1. The physician must possess the degree of skill commonly possessed by other reputable practitioners in the same field of practice.

2. He must exercise the degree of care, diligence, and judgment commonly and ordinarily exercised by other reputable members of his profession in similar circumstances.

3. He must keep abreast of progress and follow good practice, common practice, in diagnosis and treatment; he must not experiment.

4. He must not neglect or abandon his patient; he must proceed diligently, without unnecessary delay.

5. He must give his patient sufficient attention and must utilize the indicated diagnostic aids.

6. He must find or anticipate any condition reasonably determinable or reasonably likely to develop.

7. He must obtain legal consent to operate and to perform an autopsy.

8. He must give proper instructions (that is, instructions consistent with the standard of practice) for the care of the patient in his absence, and for the protection of those coming in contact with the patient.

9. He must fulfil the terms of a special contract if he makes one.

The foregoing directions for reducing and avoiding the instigation of malpractice suits will not, of course, guarantee that a physician will not be sued unjustly; for already malpractice may be regarded as a contagious disease of the social body. There are several major reasons for this condition, but two are paramount: (1) the winning of a suit inevitably encourages the filing of others as patients become increasingly "suit conscious"; and (2) such suits are difficult to defend, and the knowledge of how best to conduct such a defense is not sufficiently widespread. The inter-relationship of these two points will be obvious; for each successful defense of an unjust suit will serve as a discouragement to the filing of others. But the second of these causes of high malpractice incidence—the difficulty of conducting a defense—is dangerously enlarged by many physicians themselves. Large numbers of medical men are naive enough to believe that their patients would never file such suits and that no precautions need be taken; and yet such precautions are the only assurance of the best possible defense in the event of a suit. The most vulnerable physicians are those who know that they are maintaining at least an average standard of practice and who are therefore (and blindly) assuming that they will not be sued. This discussion is concerned with *unjust* claims; no doctor who is actually guilty of malpractice should be allowed to go free of penalty. Meritorious claims should be settled out of court—preferably before a suit has been filed.

Prompt Attention Should Be Given to Claims

Another too frequent hindrance to an adequate defense is delay in the investigation of claims; such delay is highly disadvantageous to the preparation of a defense. As a final word of warning that the physician may need every available precaution, one must consider the conditions under which most cases are heard. They are tried before juries made up of lay persons, and it is a truism that no one can say what a jury will do. This is particularly true of malpractice cases, for certainly lay jurors can not be expected to understand complex medical facts. How does a jury arrive at a decision when two expert witnesses testify that the defendant's conduct of the case did not meet the required standard, and two others declare that what the defendant did was consistent with the usual and ordinary practice in the community?

To physicians who have had little or no experience with the law and to lawyers who have little or no medical knowledge, the problem of adequately defending the unjust malpractice case seems insurmountable. And it is true that far too many such cases have been lost simply through poor defense. This is an aspect of the problem which needs a great deal more attention, particularly in areas which have become virtual "hot beds" of non-meritorious malpractice claims. At all times and to all physicians, there should be available expert advice on problems relating to the physician-patient relationship.[9] Whenever a threat is made against a physician, a carefully prepared procedure should be put into effect. Unjustified claims should be contested as thoroughly as possible. In such cases, it is sheer folly to compromise, on the theory that a slight settlement would be less expensive than the cost of defense. Such a course simply serves as an encouragement to others whose claims are not justified. This shortsighted view is largely responsible for the

[9] Regan, L. J.: Doctor and Patient and the Law, St. Louis, The C. V. Mosby Company, 1949, chap. 20.

rapid increase in the number of malpractice claims in some sections of the country. If cases based upon unjust or absurd claims are permitted to receive even a slight profitable return, there will be an incentive to bring more of them.

Be Slow to Compromise

It is a great temptation to a doctor to rid himself of a nuisance claim by making a small settlement. The unfavorable publicity, the loss of time, and the mental and emotional strain involved in defending a malpractice suit may lead the physician to compromise. But, as is so often true, the easiest way out of a situation is seldom the best. For the sake of both himself and his colleagues, the doctor should make a determined opposition to an unjustified claim.

A List of "Commandments" in Malpractice Prevention

In the final analysis, it is the physician himself who is responsible for the continuing existence of the vicious malpractice situation. The physician has generally been satisfied to pay his professional liability insurance premiums and thereafter to sit back complacently, doing nothing until he becomes a target for a malpractice claim. He must be brought to realize that his money payment is only a part of his insurance premium; a much more important part is his contribution of time, of study, and of putting into effect all possible measures to safeguard himself and his colleagues.

Prevention is the best defense against malpractice. Listed below are the 23 malpractice prophylaxis "commandments":

1. The physician should care for every patient with scrupulous attention to the requirements of good medical practice.

2. The physician must know his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. The physician should keep "ideal" medical records in every case: records that would be presentable when offered in court; records that clearly show what was done and when it was done; records that clearly indicate that nothing was neglected and that the care given met fully the standard demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the record should show it; a good method is to file a carbon copy of the letter which advises the patient against the unwise course.

5. The physician should be careful to avoid making any statement which constitutes or which might be construed as an admission of fault on his part. Such an admission, which is usable against the physician, might be made to a third party as well as to the patient at any time before the trial. Such an admission may be made by an agent or employee of the physician during the course and within the scope of the employment. It is important to instruct employees to make no statements.

6. The physician should exercise tact as well as professional ability in handling his patients. A proper professional manner and a sound attitude should be maintained at all times toward both the patient and the patient's family. The attentive physician may early sense some unsatisfactory and disturbing under-current which, by the institution of protective measures, may be prevented from developing into something much more unpleasant. Thus, if the patient is not doing well, consultation may be suggested; if the patient is dissatisfied or complaining, or if the family's attitude indicates dissatisfaction, consultation should be demanded. The use of a consultant affords, in any case, great protection against a malpractice claim.

7. The physician should refrain from overoptimistic prognoses and should avoid promising too much to the patient.

8. The physician should advise his patients of any intended absence from practice and should recommend, or make available, a qualified substitute.

9. The physician should unfailingly secure written consent for operation and autopsy.

10. The physician should carefully supervise assistants and employees and take great care in the delegation of duties to them.

11. The physician should have some knowledge of the statute of limitations and of its significance.[10]

12. In his selection of patients the physician should limit himself to such fields as are well within his qualifications. He should keep abreast of progress in the medical profession.

13. The physician should keep inviolate all confidential communications.

[10 In Wisconsin, the statutes of limitations of greatest importance to the physician are Section 330.19, subsections (3) and (5) thereof, and Section 330.27. By virtue of Section 330.19 (5), the patient, in order to claim damages against his physician for malpractice, must either bring suit within two years of the alleged event or else bring suit within six years after having given, within two years, a formal notice of his intent to sue. Section 330.27 makes the same rule apply also in those situations where the patient is sued by the physician, and where, were it not for the statutes of limitations, the patient might assert malpractice as ground for a counterclaim for damages against the physician.

Ordinarily, suit for unpaid salary, wages, or other compensation for personal services must be brought within two years; but fees for professional services are not so limited. See Section 330.21 (5). Instead, under Section 330.19 (3), the physician has six years in which to bring suit for fees.

Since a patient who is slow to pay his bills might be especially quick to respond to suit by a counterclaim based on a groundless charge of malpractice, the physician does well to wait for two years before commencing an action for his fees. The patient may then still argue that the treatment was so far below professional standards as to be non-compensable, but at least he will be barred from basing a malpractice claim on the treatment given.]

14. The physician should frequently check the condition of his equipment and make use of every available safety installation.

15. In the treatment of the patient the physician must not experiment.

16. The physician must be careful to render sufficient care to his patient in general instructions, frequency of visits, clinical and roentgen ray laboratory investigations and the like. Moreover, every precaution should be instituted for the protection of those caring for the patient and of all other contacts.

17. The patient must not be abandoned. The physician-patient relation can be terminated without liability only in certain ways and under certain conditions.

18. The physician should never reveal that he carries professional liability insurance. Except on the recommendation of his legal adviser, he should never write a letter or make any statement with reference to a malpractice claim. Immediately on being advised of even the possibility of suit, he should consult with his attorney.

19. The physician should arrive at an understanding in the matter of fees. Misunderstanding in this matter, particularly when the question of excessive fees arises, contributes an avoidable element of risk.

20. The physician should secure legal advice if he is called to attend a coroner's inquest as a witness in a case in which he has been in professional attendance.

21. The physician should realize that because of the possibility of error in transmission, it is dangerous to telephone a prescription.

22. The physician should realize that it is hazardous to sterilize any patient except when a medical indication exists.

23. Except in actual emergency, the physician should not examine a female patient unless a third person is present. There is no more serious or destructive charge than that of undue familiarity; and the only way to avoid claims of this sort seems to be to have some one else present during all examinations.

Conclusions

There must be recognition of malpractice as a problem; that the conditions created by it are harmful to the physician and injurious to the public; and that action must be taken to correct it.

The public should be informed as to (1) what constitutes malpractice, (2) how really few cases of actual malpractice occur, and (3) the major degree of responsibility which the individual has in the maintenance of his own health.

Physicians must learn what they may do to safeguard themselves, and must put into effect every possible precaution against an unjust malpractice accusation.

Addenda

I. Consent to Operation

Place _____

Date _____

1. I hereby authorize and direct Dr. _____ to perform the following operation upon me_____

_____

_____

and to do any other procedure that (their) (his) judgment may dictate during the above operation.

2. I understand that the surgeon (surgeons) will be occupied solely with the surgery, and that the administration and maintenance of the anesthesia are independent functions, and will be in charge of Dr. _____ I consent to the administration of such anesthetic, or anesthetics, as Dr. _____ may deem advisable in my case.

3. It has been explained to me that I may be sterile as a result of this operation, although no such result is warranted or guaranteed. I understand what the term sterility means and, in giving my consent to the operation, I have in mind the possibility (probability) of such a result.

A.M. Signed _____

Hour _____P.M. Witness _____

4. I join in authorizing the performance, upon my (husband) (wife), of the surgery consented to above. It has been explained to me that, as a result of the operation, my (husband) (wife) may be sterile.[1]

Date _____ Signed _____

A.M. Witness _____

Hour _____

P.M.

1. Cross out paragraphs not applicable to particular case.

II. Consent to Operation upon Minor

Place _____

Date _____

1. I (we) being the parent(s), guardian, custodian of a minor of the age of ____, do hereby authorize and request Dr. _____ to perform such surgical operation on the person of said _____, a minor, as the judgment of said Dr. _____ may dictate.

2. I (we) also authorize and request the employment of such anesthetic or anesthetics as may be deemed suitable in the judgment of the said Dr. _____, or in the judgment of the anesthetist selected to administer the anesthetic or anesthetics in this case.[2]

2. A similar consent form may, and should, be used in the case of a patient who is incompetent; signed by guardian, custodian, or other person legally responsible for the incompetent.

A.M. Signed _____( )

Hour _____P.M. _____

Witness _____

III. Consent to Observers and/or Photographs and/or Televising

In the interests of science and the furtherance of medicine, I, the undersigned, do hereby consent to and authorize _____ Hospital, and the Operating or Treating Surgeon and such doctors as may be assisting him, to examine and operate or treat me in the presence of other than the usual surgical staff.

I further authorize and consent to the taking of photographs and such subsequent use thereof as may be deemed advisable by said hospital and/or doctor, or doctors.

I further authorize and consent to the televising of any operative or other procedure performed or carried out upon me.

Dated _____ Signed _____

Witness _____ Witness _____

IV. Patient Fails to Carry Out Advice

Note. When a patient neglects or fails to carry out advice, it is desirable to have the facts established in writing. It may be wiser to withdraw from the case (See VII). This is a matter for the judgment of the physician in the particular case.

SAMPLES[3]

3. Substance of letter to patient to be changed to fit the particular facts and circumstances. Carbon copy, with proof of mailing of original written thereon, to be filed with medical case record.

Place _____
Date _____

A.
Name of Patient
Address
Dear Mr. _____:

At the time of my examination of your ankle this afternoon, I advised you of the desirability of having x-rays made. This you refused to do.

Upon your insistence that I treat your ankle and foot, without benefit of x-rays, I agreed to do my best in the circumstances, but as I advised you this afternoon, and must repeat now, I cannot establish, without x-rays, whether or not you have incurred a fracture.

In your own interest, I urge that you have an immediate x-ray study made of your foot and ankle.

Yours very truly,

B.
Dear Mrs. _____:

Upon the history you gave me and my findings on examination, both of this date, I am not able, as I told you at the time of your visit, to rule out pregnancy as the cause of the vaginal bleeding of which you complain.

You have told me that you will not submit to a pregnancy test. I again now advise you of its desirability. I hope you will come in tomorrow morning prepared, as I instructed you, to have the test made. If you continue to refuse to submit to this test, it will be necessary to have a consultant see you tomorrow, if I am to continue to advise you.

Yours very truly,

C.
Dear Mrs. _____:

When, in response to your call today, I saw your husband at your home, I told you my opinion was that he is very seriously ill with pneumonia, and that he should be immediately hospitalized. You refused to permit me to have him removed to the hospital. I told you that I am willing to do the best I can for him under the circumstances, but that he could be better cared for and he would be safer, with less likelihood of complication, in the hospital.

Your husband's condition is such that the matter cannot be discussed with him, so I hope that you will now, after giving the matter more thought, authorize his removal to the hospital.

Yours very truly,

D.
Dear Mrs. _____:

You brought your seven-year old boy in today for me to see. He has a deep, penetrating wound on the sole of his foot, apparently resulting from his stepping on a nail. You thought that it had been received in a neighboring stable.

I advised you that the boy should immediately be given an injection of tetanus antitoxin. You refused to permit me to administer this to him, stating that you had heard of two children who had severe reactions following such prophylactic treatment.

I told you that I would make a preliminary test which would warn us of the likelihood of severe reaction, but that I could not guarantee that result or any result. You reiterated your refusal.

I cannot give the boy this treatment, or any treatment, without your consent. I urgently recommend that you permit me, or some other physician of your choice, to administer a preventive dose of tetanus antitoxin to your boy without further delay.

Yours very truly,

V. Patient Fails to Keep Appointment

SAMPLES[4]

4. When a patient fails to keep an appointment, or discontinues treatment before he should, it is desirable to send him a letter, incorporating the pertinent facts and the recommendations. File a carbon copy, endorsed with a certificate of mailing, with medical case record. Registered mail may be used.

Place _____
Date _____

A.
Name
Address
Dear Mr. _____:

My records indicate that you failed to keep your appointment of _____ (date), and that you have not made any subsequent appointment or appearance in the office.

In your own interest, may I call to your attention the fact that further professional attention is, in my opinion, definitely needed. If there is some reason why you prefer not to return to this office, I urge that you immediately seek other competent professional care. I shall be glad to give the benefit of my knowledge of your case to your subsequent physician, should you elect to receive the needed attention at other hands.

Yours very truly,

B.
Dear Mrs. _____:

You have not returned, as arranged, since, at your request, I examined you on last Friday.

The history you gave of "spotting" between periods over the last several months, and my findings on examination, which I related to you, are of such significance that, as I endeavored to impress upon you when I made an appointment for you to return with your husband, I must urge upon you the advisability of having immediate medical attention.

If you do not wish to return to me, you should consult another physician at once.

Yours very truly,

C.
Dear Mrs. _____:

You failed, again, today to appear in accordance with your appointment at the Radiologist's office so that a check-up x-ray could be made of your fractured wrist.

I have previously urged upon you the necessity of having your cooperation to improve the likelihood of a favorable result.

You should not be heard to complain of the end result, if it is not satisfactory, when you refuse or neglect to follow the advice of your physician.

I now request that you appear at my office at ten o'clock tomorrow morning. I am arranging to have x-rays made at that time and to have a specialist in orthopedic surgery see your arm.

Yours very truly,

VI. Patient Discharges Physician From Case[5]

5. If a physician justifies his failure to continue in attendance upon a patient upon either his having withdrawn from the case or of having been discharged by the patient, the burden of proof of such contention is upon him—hence the desirability, if not the actual necessity, of having written evidence available.

Dear Mr. and Mrs._____:

This is confirmation, and my acknowledgment, of the fact that you have, as of this date, discharged me from further professional attendance upon you in your current illness.

Should you desire, I shall be glad to cooperate with the physician you now call, in supplying him with such information as I have gained in respect to your case.

Yours very truly,

VII. Physician Withdraws From Case

Note. A physician may withdraw from attendance upon a patient, but he must give reasonable notice of his intention to do so and must allow the patient reasonable time and opportunity to fill his place. If the fact, whether a physician did withdraw from professional attendance upon a patient, became an issue in the case the burden of proof falls upon the physician. For this reason, it is desirable that written evidence be available.

It is a serious question of judgment, whether, when a patient fails to cooperate or refuses to follow advice, the physician should continue on the case. It is recommended that, if the physician decided to continue to care for an uncooperative patient, who, for example, refuses to have an indicated x-ray study made, he should demand and require consultation.

SAMPLES[6]

6. Letters should be sent and carbon copy filed. The wording should be simple and direct, but the intent and meaning must be clear and certain.

Place _____
Date _____

A.
Name
Address
Dear Mr. _____:

You have repeatedly failed to follow my advice and recommendations.

I am therefore advising you of my intention to withdraw from further professional responsibility in connection with your case. To allow you a reasonable opportunity to secure another physician, I shall be available, at your request, to render you service for three days from your receipt of this letter, but not thereafter. In this period of time, in this community of several hundred physicians, you can readily fill my place.

I shall be glad to give, to any reputable physician of your choice, the benefit of such knowledge as I have gained of your case.

Yours very truly.

B.
Dear Mr. _____.

You consulted me this afternoon in connection with an injury to your foot and ankle. At that time, upon your refusal to have x-rays made of the injured area, I advised you that I could not undertake to render professional service to you.

So that there may be no misunderstanding, I am confirming these facts in writing.

Yours very truly.

C.
Dear Mrs. _____:

As I told you this morning, I cannot longer continue to be professionally responsible for the care of your little boy. This decision is necessitated by the fact that you have repeatedly refused to permit me to make the detailed and thorough study of his condition which I regard as indicated and vital.

Please secure other medical attention at once. In the meantime, and for a reasonable time, I shall remain available, at your request, to render any routine or emergency service that may be required.

I shall, of course, be glad to offer to Tommy's new physician the knowledge of his case which I have been permitted to acquire.

Yours very truly.

D.
Dear Mrs. _____:

You failed to keep your appointment this week.

At the time you received your injection last week a portion of the needle broke off in your tissues. You were at once advised of this accident. As I told you, after preliminary search, I was unable to recover the broken piece without anesthesia and incision, and recommended that localization studies be made prior to undertaking definitive search.

I again recommend that procedure and will make arrangements at your request and responsibility.

Yours very truly.

The Revised Medical Practice Act

IMPORTANT fundamental improvements in the law which protects the people against unqualified practitioners in the health field have been accomplished during the last two sessions of the Wisconsin Legislature. Chapter 147 of the Wisconsin Statutes, referred to as the Medical Practice Act, has been both strengthened and modernized.

The Medical Practice Act defines the minimum qualifications required by the state of all practitioners from cultist to physician. It prescribes the make-up of the Board of Medical Examiners and outlines its functions and responsibilities. The Act sets forth the prerequisites for licensure, the method of making application, and the nature of the examinations in several of the practicing fields. Of equal importance, it spells out many of the medical crimes and provides the enforcement procedures and penalties.

Some provisions of the former Act dated back to Territorial days and were so antiquated as to be virtually meaningless in light of present-day medical education and practice. After several years of intensive study the State Medical Society offered to the Legislature its recommendations. For the most part those recommendations have been adopted.

Because of the importance and the extent of the legislative enactments which affect the Medical Practice Act, it is reprinted here in its entirety.

147.01 Definitions. (1) The "basic science law" is sections 147.01 to 147.12, inclusive, and as used therein:

(a) To "treat the sick" is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts, for compensation, direct or indirect, or in the expectation thereof.

(b) "Disease" includes any pain, injury, deformity, or physical or mental illness or departure from complete health and proper condition of the human body or any of its parts.

(c) The "basic sciences" are anatomy, physiology, pathology and physical diagnosis.

(d) The "board" is the state board of examiners in the basic sciences.

(2) Sections 147.01 to 147.12, inclusive, shall not apply to or affect persons making application for examination to hold a certificate, under chapter 152, as a dental hygienist nor shall the above sections apply to optometrists; provided further, that the exemption contained in this subsection shall likewise apply to all those who prior to July 1, 1952, file an application for a license to practice dentistry under the provisions of chapter 152.

147.02 Practice. No person shall treat, or attempt to treat, the sick unless he shall have a certificate of registration in the basic sciences, and shall have recorded the same with the county clerk in the manner provided in s. 147.14, and shall have complied with all other requirements of law. This section shall not affect the exemptions provided by subs. (1) and (2) of s. 147.19, nor shall it be construed to require a certificate of registration in the basic sciences for the practice of nursing by persons registered under chapter 149 nor for the practice of physical therapy by persons registered under s. 147.185.

147.03 Board. The governor, with the advice and consent of the senate, shall appoint the state board of examiners in the basic sciences. The board shall consist of 3 lay educators, none of whom shall be

on the faculty of any department teaching methods of treating the sick. The term of office shall be 6 years. A vacancy shall be filled for the unexpired term. The board shall within 30 days of appointment organize by the election of a president, secretary and treasurer. The compensation of the members of the board shall be $10 for each day actually spent and actual and necessary expenses.

147.04 Other boards. No examining board for any branch of treating the sick shall admit to its examinations or license or register any applicant unless such applicant first present a certificate of registration in the basic sciences. Any such board may by rule accept such certificate in lieu of examination in those subjects.

147.05 Application. Application for a certificate of registration in the basic sciences shall be made to the board of examiners in the basic sciences, accompanied by sufficient and satisfactory evidence of good moral character and preliminary education equivalent to graduation from an accredited high school of this state, and a fee of ten dollars. If the applicant was on February 1, 1925, attending a professional school, high school education shall not be required.

147.06 Examination. Examination shall be in the basic sciences only, shall be conducted not less than 4 times a year at such times and places as the board shall fix, and shall be both written and by demonstration or other practical test. No applicant shall be required to disclose the professional school he may have attended or what system of treating the sick he intends to pursue. In lieu of its own examination, the board may accept, either in whole or in part, the certificate of the national board of medical examiners provided that certification by the national board is accepted by the state board of medical examiners in whole or in part and that such certification is accepted by the basic science boards of at least 6 other states.

147.07 Certificate. If the candidate attains a grade of 75 per cent in each subject, he shall receive a certificate in the basic sciences, signed by the president and secretary. If he fails in one subject only, he may be re-examined in that subject at any examination within one year without further examination fee. If he fails in 2 or more subjects he must apply anew and stand examination in all subjects.

147.08 Reciprocity. The board may issue certificate to an applicant who presents sufficient and satisfactory evidence of having passed examinations in the basic sciences before a legal examining board or officer of another state, or of a foreign country, if the standards are as high as those of this state, and upon payment of a fee of fifteen dollars.

147.09 Previous practice. Any person who, on February 1, 1925, was regularly licensed or registered in the state of Wisconsin to treat the sick need not be registered under the basic science law. Any person who, on February 1, 1925, was not registered or licensed in the state of Wisconsin to treat the sick, but nevertheless on that date was lawfully engaged in this state in treating the sick, shall be registered upon presenting to the board, within sixty days after this section goes into effect, an application therefor, with sufficient and satisfactory evidence that he was, on such date, lawfully engaged in this state in treating the sick, and is of good moral character, and upon the payment of a registration fee of five dollars. The certificate shall recite registration solely as a person who, on February 1, 1925, was lawfully engaged in this state in treating the sick. Such certificate shall be in force only when filed with the county clerk in the manner provided in section 147.14.

147.10 Revocation. Certificate of registration in the basic sciences shall be subject to revocation for the causes and in the manner provided in section 147.20.

147.11 Review. The action of the board in granting or denying a certificate shall be subject to review by appeal in the manner provided in chapter 227, and any state examining board for any branch of treating the sick may take such appeal as a party aggrieved.

147.12 Administration. The board shall keep a complete record in which shall be entered all applications, examinations, registrations, fees, decisions, orders and proceedings. It shall from time to time from lists furnished by the state civil service commission, appoint such competent and recognized experts as shall be necessary to assist in the examinations, and necessary clerks. They shall receive such compensation as the board shall fix. On or before August first of each year, the board shall file with the governor a report of all receipts, disbursements and transactions for the preceding fiscal year. The disbursements of the board shall not exceed the fees received.

147.13 Examiners. (1) The Wisconsin state board of medical examiners shall consist of 8 members appointed by the governor, 7 of whom shall be licensed resident doctors of medicine and one of whom shall be a licensed resident doctor of osteopathy. The 7 doctors of medicine may, but need not, be selected from nominees of the state medical society and the doctor of osteopathy from nominees of the Wisconsin osteopathic association. The appointment of each member shall be for 4 years. No instructor, stockholder, member of, or person financially interested in any school, college or university having a medical department, or of any school of osteopathy, shall be eligible. Each member of the board shall be paid such compensation as the board determines, and, except for the secretary, not more than $15 per day, when actually and necessarily engaged in his duties. The secretary shall receive such compensation as the board determines, but not less than $1800 annually.

(2) The board shall hold its Annual Meeting on the second Tuesday of January at Madison, and it shall meet at least 3 other times during the year at such places as it determines. It shall elect annually at its January meeting a president, a vice president and a secretary-treasurer. The board shall maintain its office in Madison. The president, vice president or secretary-treasurer may administer oaths. The secretary-treasurer shall furnish such bond as the board shall require, and shall receive all moneys and pay the same into the state treasury.

(4) The board shall employ necessary assistants and fix their compensation.

(5) The board shall have a common seal, and keep a record of its proceedings and a register of applications, and licenses and certificates of registration issued. It shall make annual report of its proceedings to the governor on June thirtieth, including detailed statement of money received and expense of operation.

(6) The board shall investigate complaints of violation of this chapter, notify prosecuting officers, and institute proceedings.

147.14 Practice. (1) No person shall practice or attempt or hold himself out as authorized to practice medicine, surgery, or osteopathy, or any other system of treating the sick as the term "treat the sick" is defined in s. 147.01 (1) (a) without a license or certificate of registration from the state board of medical examiners, except as otherwise specifically provided by statute.

(2) (a) No person without a license or certificate or registration from the state board of medical examiners shall have the right to testify in a professional capacity on a subject relating to medical treatment, as a medical or osteopathic physician or practitioner of any other form or system of treating the sick, as defined in s. 147.01; provided that a medical or osteopathic physician, licensed to practice in another state, may testify as the attending or examining physician or surgeon to the care, treatment, examination or condition of sick or injured persons whom he has treated in the ordinary course of his professional practice for the sickness or injury which is the subject of the judicial inquiry in any action or proceeding in which he is called as a witness.

(b) A court may permit any person to testify as an expert on a medical subject in any action or judicial proceeding where proof is offered satisfactory to the court that such person is qualified as such expert.

(c) A nonresident witness shall not be permitted to testify as an attending or examining physician and surgeon, or as an expert witness on a medical subject unless the party calling such witness has served on the opposing party a 5-day written notice in advance of calling such witness to testify, stating the name of such witness, his residence and business address. The court for good cause shown may shorten such notice to 3 days.

(3) No person not possessing a license to practice medicine and surgery, osteopathy, or osteopathy and surgery, under section 147.17, shall use or assume the title "doctor" or append to his name the words or letters "doctor," "Dr.," "specialist," "M. D.," "D. O." or any other title, letters or designation which represents or may tend to represent him as a doctor in any branch of treating the sick.

(4) No person shall practice medicine, surgery, or osteopathy, or any other system of treating bodily or mental ailments or injuries of human beings, under any other Christian or given name or any other surname than that under which he was originally licensed or registered to practice in this or any other state, in any instance in which the Wisconsin state board of medical examiners shall, after a hearing, find that practicing under such changed name operates to unfairly compete with another practitioner or to mislead the public as to identity or to otherwise result in detriment to the profession or the public. This subsection does not apply to a change of name resulting from marriage or divorce.

147.15 Application. Application may be made at the time and place designated by the board or at a regular meeting. Applicants for license to practice medicine and surgery shall present satisfactory evidence of good moral and professional character, and of having completed a preliminary education equivalent to graduation from an accredited high school of this state, and also a diploma from a reputable professional college. Applicants for license to practice medicine and surgery, shall present to the board a diploma from a reputable medical or osteopathic college with standards of education and training substantially equivalent to the university of Wisconsin medical school, approved and recognized by the board. Before approving and recognizing any such college or school, the board shall conduct an investigation and during the course thereof shall hold a public hearing with notice to all interested parties, at which any person may be heard. The board may designate an agent, including one or more board members, to conduct a portion or all of such investigation to determine the facts upon which the board shall make its findings. The findings and any action taken by the board with reference to approval or recognition of a school or college may be reviewed in the manner provided in ch. 227. The applicant shall present also satisfactory evidence of having completed a college course in physics, chemistry and biology, substantially equivalent to the premedical course at the university of Wisconsin, and if the professional college from which a diploma is presented does not require for graduation a hospital internship of at least 12 months in addition to a 4 years' course, a certificate of completion of such internship in a reputable medical or osteopathic hospital. Each applicant shall file a verified statement that he is familiar with the state health laws and the rules and regulations of the state board of health relating to communicable

diseases. The application shall be accompanied by a fee, to be fixed by the board at not more than $40 and $5 additional for license if issued. An immigrant applicant shall present satisfactory evidence of having first citizenship papers, and if his professional education was completed in a foreign college, the application shall be accompanied by a fee of $75, and the further fee of $5 upon the issuance of license shall not be required. Applicants shall pay also the cost of translation into English by the board of documents and papers in a foreign language.

147.151 Temporary educational certificates. (1) Application for a temporary educational certificate may be made to the board by a person having training in medicine and surgery satisfactory to the board for purposes of this section. Such certificate shall entitle the holder to take postgraduate educational training in a teaching hospital which maintains standards for this training prescribed by the board, which standards shall be commensurate with those of nationally recognized accrediting organizations. Such certificate may be issued for a period not to exceed 1 year, and, in the discretion of the board, may be renewed annually for not more than 2 additional years. The fee for such certificate shall be fixed by the board at not more than $10 per annum, which amount shall also be paid for each renewal thereof. Not more than 25 such certificates shall be issued in any one year and no more than 75 shall be outstanding at any one time. The holder of such a certificate may, under the direction of a person licensed to practice medicine and surgery in this state, perform services requisite to the training authorized by this section. Acting under such direction, the holder of such certificate shall also have the right to prescribe drugs other than narcotics, and to sign any certificates, reports or other papers for the use of public authorities which are required of or permitted to one licensed to practice medicine and surgery. The holder of such a certificate shall confine his training and practice within the hospital in which he is taking such postgraduate education. Neither he nor the hospital may receive any fees or other income for his services from any patients treated by him during the course of such training.

(2) The purpose of this section is solely to provide opportunities in this state for the postgraduate education of certain persons having training in medicine and surgery satisfactory to the board, without compliance with the licensure requirements of this chapter. Nothing herein contained shall be construed as changing in any respect the requirements for licensure to practice medicine and surgery in this state. The violation of the provisions hereof by the holder of such a certificate shall constitute cause for the revocation thereof.

147.16 Examination. Having complied with s. 147.15, the applicant shall be examined in medicine and surgery and further examined in the subjects taught in reputable professional colleges.

147.17 License. (1) If 6 members find the applicant for license qualified, it shall issue a license to practice medicine and surgery, signed by the president and secretary-treasurer and attested by the seal. Before granting a license by reciprocity, the board shall conduct an investigation in the manner provided in s. 147.15 to determine whether the requirements for licensure in the state in which the applicant for reciprocity is licensed are equivalent to those of this state. If it finds that the requirements in another state are equivalent to those of this state, the board may issue a license to practice medicine and surgery without written examination to a person holding a license to practice medicine and surgery, or osteopathy and surgery, in such other state, upon presentation of the license and a diploma from a reputable professional college approved and recognized by the board, or an honorably discharged surgeon of the armed services of the United States, or of the federal public health service, upon filing of a sworn and authenticated copy of his discharge; provided that such discharge was within one year of such application for license by reciprocity. In lieu of its own examination, the board may accept, either in whole or in part, the certificate of the national board of medical examiners. Fee for license with or without written examination shall be fixed by the board at not less than the reciprocity fee in the state whose license the applicant presents, and in no case less than $75. A person licensed before 1916 to practice osteopathy shall be licensed to practice surgery upon presenting satisfactory evidence of having completed a course in surgery at a reputable osteopathic college, requiring not less than 20 months' actual attendance, and the regular examination of the board in surgery, and being found qualified by 6 members. The board may deny the application of one not 21 years of age. No certificate of registration shall be considered equivalent to a license.

(3) A person licensed to practice osteopathy and surgery may apply to the board to be examined in materia medica and pharmacology as may be required by the board. Such applicants shall be given the same examination in materia medica and pharmacology as is given to applicants from medical colleges at any regular meeting of the board. Such application shall set forth the date such person was licensed to practice, the number of years and place or places in which he has practiced together with a statement from a reputable osteopathic college that applicant has successfully completed a refresher course approved by the board in materia medica and pharmacology consisting of not less than 64 hours of lectures and 60 hours of laboratory work while in actual attendance at such college; if the applicant shall be unsuccessful he may apply for re-examination at any subsequent meeting of the board. The application shall be accompanied by

a fee of $20. Upon successfully passing such examination and payment of a fee of $5 and upon surrender of the old license the board shall issue a new license to practice medicine and surgery.

(4) Whenever the statutes authorize or require a practitioner of medicine to do or perform an act or to issue any statement, affidavit or certificate such statute shall be construed to include those practitioners of osteopathy and surgery who hold such new license to practice medicine and surgery.

(5) Sections 147.15 and 147.16 (as amended in 1949) and sections 147.17 (3) and (4) shall not be construed to abrogate the existing rights, privileges and immunities of any person licensed to practice osteopathy or osteopathy and surgery who do not hold a license to practice medicine and surgery.

(6) A license to practice medicine and surgery granted to an osteopathic applicant shall not authorize the holder to use the title of "doctor of medicine" nor the letters "M. D."

147.175 Annual registration of physicians. (1) Every person licensed to and engaged in or entering upon the practice of medicine and surgery, osteopathy, or osteopathy and surgery, in this state, shall, in the month of January of each year, register with the secretary of the state board of medical examiners, upon a form to be furnished by the board. The registration form, to be signed by each registrant, shall contain his name, his residence address, the name of the place and the address at which he is engaged in practice, and any other relevant information for the purpose of identifying the registrant which the board may prescribe. Persons licensed or relicensed in this state to practice medicine and surgery, osteopathy, or osteopathy and surgery, subsequent to January 31 of a given year shall register as required by the terms of this section within 30 days after being so licensed. The secretary-treasurer of the board, on or before December 1 of each year, shall mail or cause to be mailed to every person registered hereunder the registration form above required. Each person registered hereunder shall display his proper registration certificate conspicuously in his office at all times.

(2) Each registrant shall pay for such registration a fee to be fixed by the Wisconsin state board of medical examiners for each given year, which fee shall not exceed $3 in any year; provided that those who register after January 31 of a given year, shall likewise pay whatever fee has been fixed for that year.

(3) On or before March 10 in each year the secretary-treasurer of the state board of medical examiners shall cause to be published and mailed to each person registered hereunder, a printed list of those so registered, which list shall be divided according to the branch of healing in which the registrant is licensed. The secretary-treasurer of the board shall also cause to be mailed a copy of such published list to the secretary of state, the district attorney of each county, each local board of health, the sheriff of each county, the chief of police of each community, and to any other public official who may request or have need thereof.

(4) Every registration made as provided in this section shall be presumptive evidence in all courts and other places that the person named therein is legally registered for the year covered by such registration.

(5) No registration shall be permitted by the secretary of the Wisconsin state board of medical examiners in the case of any person who has been found guilty of any of the unprofessional acts described in section 147.20, and upon conviction for any of said offenses, the registration of any such person shall be deemed automatically annulled upon receipt by the secretary of the board of a certified copy of the information, verdict and judgment, as provided in section 147.20 (3), subject to such registrant's right of appeal. A registrant whose license has been revoked and subsequently restored under the provisions of section 147.20 (4) shall be registered by the board upon tendering a certified copy of the order of the trial court restoring his license, together with an application for registration and the registration fee.

(6) The provisions of this section shall not be applicable to any physician while serving in the armed forces of the United States or of an allied government.

(7) If any subsection, paragraph or provision of this section, or its application to any person or circumstance shall be held unconstitutional, such decision shall not affect the constitutionality of any other subsection, paragraph or provision of this section or its application to other persons or circumstances.

147.18 Itinerants. Itinerant practitioners of medicine, surgery or osteopathy or of any form or system of treating the afflicted shall obtain an annual license in addition to the regular license or certificate of registration, and shall pay therefor two hundred fifty dollars per annum. Persons practicing medicine, surgery or osteopathy or professing or attempting to treat or heal ailments or injuries of the human body who go from place to place at regular or irregular intervals less frequently than once a week, are itinerant practitioners.

147.185 Physical therapy. (1) PRACTICE OF PHYSICAL THERAPY. (a) The practice of physical therapy is the treatment of disease as defined in s. 147.01 by the use of physical, chemical and other properties of heat or cold, light, water, electricity, massage, and therapeutic exercises, including posture and rehabilitation procedures, but the use of Roentgen rays and radium for any purposes, and the use of electricity for surgical purposes, including cauterization, are not included in the practice of physical therapy.

(b) No person shall practice or hold himself out as authorized to practice physical therapy, nor shall any person designate himself as a physical therapist, physiotherapist, physical therapy technician,

or use the initial "P.T.," "P.T.T.," or "R.P.T." or any other letters, words, abbrevations, or insignia indicating that he is a physical therapist, without a certificate of registration issued by the board of medical examiners nor unless he practices under a prescription and the direct supervision of a person licensed to practice medicine and surgery. Nothing in this section shall prohibit any person licensed or registered, in this state, under another law, from engaging in the practice for which he is licensed or registered.

(2) Application. An applicant for a certificate of registration as a physical therapist shall file written application on forms provided by the board. The applicant shall present satisfactory evidence that he is at least 20 years of age, is of good moral character, has obtained a high school education or its equivalent, and has been graduated from a school of physical therapy with standards of education and training substantially equivalent to that of the University of Wisconsin. He shall pay to the board $15 and present himself for examination at the first meeting thereafter at which examinations are to be held.

(3) Examination. The examination shall be both scientific and practical in the applied sciences of anatomy, neuroanatomy, kinesiology, physiology, pathology, psychology, physics, physical therapy, as defined in this section, applied to medicine, neurology, orthopedics, pediatrics, psychiatry, surgery and medical ethics, technical procedure in the practice of physical therapy, and such other subjects as the board may determine to be necessary. The board shall select a state examining committee for physical therapy, and may do so from a list submitted by the Wisconsin chapter of the American physical therapy association, to assist it in carrying out the provisions of this section, which committee shall consist of 3 physical therapists who, after the initial appointment, shall be registered by the board and shall have had not less than 3 years of experience in the practice of physical therapy in this state immediately preceding his appointment. The committee shall elect annually one of their members as president and another as secretary. They shall receive the same compensation and reimbursement as members of the board. The terms of office of the members first appointed shall continue for the following periods: one for 1 year, one for 2 years, and one for 3 years. Upon the expiration of such terms the board shall appoint a successor for a term of 3 years.

(4) Certificate. If the board finds the applicant qualified it shall issue a certificate of registration which shall expire on February 1 of each year and shall be renewed only upon application and the sending of a $3 annual renewal fee to the secretary of the state examining committee for physical therapy on or before January 31. Upon receipt of such application, the examining committee shall send the application and fee to the board for renewal. A renewal fee of $7 shall be paid by any physical therapist who seeks reregistration but who fails to renew his application on or before February 1 of any year. If the applicant has failed to renew his certificate for a period of at least 5 years, the board shall require the applicant to take a refresher course approved by the board before issuing a renewal certificate if after oral examination, the committee recommends to the board that such refresher course is necessary. If the applicant for reregistration has been guilty of conduct that would afford a ground for revocation under s. 147.20 the board may so find and refuse to reregister such applicant.

(5) Registration without examination. The board may issue a certificate of registration without examination to any person who applies on or before December 31, 1953, and who furnishes the board with sufficient and satisfactory evidence that, on the effective date of this section he had practiced physical therapy in this state and possesses the prerequisites for examination set forth in sub. (2). The board may issue a certificate of registration in physical therapy without examination to an applicant who presents evidence satisfactory to the board of having been licensed or certified as a physical therapist in another state or foreign country with standards determined by the board to be as high as those of this state. At the time of making such application the applicant shall pay a fee of $10. The board may also issue without examination a permit to practice physical therapy for not to exceed 6 months to any person who meets the qualifications of this section upon certification that he has been assigned to this state on a temporary basis to assist in a medical emergency and upon the payment of a $2 permit fee.

(6) Previous practice of massage and hydrotherapy. Any person who, on the effective date of this section, is practicing massage and hydrotherapy in this state under a certificate of registration issued pursuant to the provisions of s. 147.185 as that section existed heretofore, shall have the right to continue so to practice under such certificate and the term "massage and hydrotherapy" shall be deemed to include the use of galvanic generator, diathermy, infra red ray, and ultra violet light for massage purposes. Nothing contained herein shall limit the existing authority of the board to revoke such certificate for cause, and in addition the board may require the holder of such certificate to demonstrate by examination his fitness to use the instrumentalities enumerated in this section. Lack of such fitness shall constitute cause for revocation of such certificate. No such certificate holder shall treat a specific disease except on the advice of a licensed medical physician.

(7) Chiropractic not affected. Nothing in this section shall be construed to restrict, inhibit or limit the practice of chiropractic as now practiced in Wisconsin, and as taught by accredited schools or colleges of chiropractic.

147.19 Exceptions. (1) Sections 147.14 to 147.18, shall not apply to commissioned surgeons of the

army, navy, federal health service, or to medical or osteopathic physicians of other states or countries in actual consultation with resident licensed practitioners of this state, nor to the gratuitous prescribing and administering of family remedies or treatment rendered in an emergency.

(2) None of the provisions of this chapter or the laws of the state regulating the practice of medicine or healing shall be construed to interfere with the practice of Christian Science, nor shall any person who selects such treatment for the cure of disease be compelled to submit to any form of medical treatment.

147.195 State medical grievance committee. The state health officer, the president of the state board of medical examiners, and the attorney-general or deputy attorney-general are hereby constituted ex officio a state medical grievance committee, to investigate, hear, and act upon practices by persons licensed to practice medicine and surgery under s. 147.17, that are inimical to the public health. The state health officer shall be chairman of the committee. Meetings of the committee shall be held at the call of the chairman. Any member thereof shall have power to subpœna and swear witnesses, and take evidence. The committee shall have the power to warn and to reprimand, when they find such practice, and to institute criminal action or action to revoke license when they find also probable cause therefor under criminal or revocation statute, and the attorney-general may aid the district attorney in the prosecution thereof. The records of said committee shall be kept by and be in the custody of the chairman thereof. No member of said committee shall receive any extra compensation therefor, nor other than his actual expenditures in attending upon his duties thereon. All divisions, officials and employes of state and local government are authorized to co-operate with the committee in conducting investigations and by making available to it pertinent data in their possession.

147.20 Revocation. (1) The words "immoral or unprofessional conduct" as used in this section mean: (a) Procuring, aiding or abetting a criminal abortion; (b) advertising in any manner either in his own name or under the name of another person or concern, actual or pretended, in any newspaper, pamphlet, circular, or other written or printed paper or document the curing of venereal diseases, the restoration of "lost manhood," the treatment and curing of private diseases peculiar to men or women, or the advertising or holding himself out to the public in any manner as a specialist in diseases of the sexual organs, or diseases caused by sexual weakness, self-abuse or excessive indulgences, or in any diseases of a like nature or produced by a like cause, or the advertising of any medicine or any means whatever whereby the monthly periods of women can be regulated or the menses re-established, if suppressed, or being employed by or in the service of any person, or concern, actual or pretended so advertising; (c) the obtaining of any fee; or offering to accept a fee on the assurance or promise that a manifestly incurable disease can be or will be permanently cured; (d) wilfully betraying a professional secret; (e) indulging in the drug habit; (f) conviction of an offense involving moral turpitude; (g) engaging in conduct unbecoming a person licensed to practice or detrimental to the best interests of the public.

(2) Upon verified complaint in writing to the district attorney charging the holder of a license or certificate of registration from the state board of medical examiners or the state board of examiners in chiropractic with having been guilty of immoral or unprofessional conduct or with having procured his certificate or license by fraud or perjury, or through error, the district attorney shall bring civil action in the circuit court against the holder and in the name of the state as plaintiff to revoke the license or certificate. The court may appoint counsel to assist the district attorney and either party may demand a jury. No one shall be privileged from testifying fully or producing evidence, but he shall not be prosecuted or subject to penalty on account of anything about which he so does, except for perjury in so doing. If the court or the jury finds for the plaintiff, judgment shall be rendered revoking or suspending the license or certificate, and the clerk of the court shall file a certified copy of the judgment with the board of medical examiners or the state board of examiners in chiropractic, as the case may be. The costs shall be paid by the county, but if the court shall determine that the complaint made to the district attorney was wilful and malicious and without probable cause, it shall enter judgment against the person making the complaint for the costs of the action, and payment of the same may be enforced by execution against the body as in tort actions.

(3) When any person licensed or registered by the board of medical examiners is convicted of a crime committed in the course of his professional conduct, the clerk of the court shall file with the board of medical examiners a certified copy of the information and of the verdict and judgment, and upon such filing the board shall revoke or suspend the license or certificate. The board of medical examiners shall also revoke or suspend any such license or certificate upon satisfactory proof being made of the conviction of such license or certificate holder in a federal court of a crime committed in the course of his professional conduct. The action of the board in revoking or suspending such license or certificate may be reviewed in the manner provided in chapter 227.

(4) When a license or certificate is revoked no license or certificate shall be granted thereafter to such person. Any license or certificate heretofore or hereafter revoked may be restored by subsequent order of the trial court, but only after a first revocation, upon notice to the district attorney who prosecuted, or, in the event of his disability, his suc-

cessor in office, upon written recommendation by the state board of medical examiners, and upon findings by the court that the applicant for restoration of license or certificate is presently of good moral and professional character and that justice demands the restoration.

(5) When a license or certificate is suspended, it shall be suspended for a definite term, but not to exceed 2 years. The authority suspending a license may restore it at any time when satisfied that justice demands the restoration.

(6) A license or certificate of registration may be voluntarily surrendered by its holder and shall be reissued by the board only when justice demands such reissuance. The action of the board may be reviewed in the manner provided in ch. 227.

147.205 Injunction to enforce chapter 147. (1) If it appears upon complaint to the board of medical examiners by any person or it is known to the board that any person is violating any of the provisions of chapter 147, except sections 147.24 and 147.25, the said board or the district attorney of the proper county may investigate and may, in addition to any other remedies, bring action in the name and on behalf of the state of Wisconsin against any such person to enjoin such person from such violation or violations of this chapter.

(2) If it appears upon complaint to the board of examiners in chiropractic by any person or it is known to the board that any person is violating any of the provisions of sections 147.23, 147.24 and 147.25, the said board or the district attorney of the proper county may investigate and may, in addition to any other remedies, bring action in the name of and on behalf of the state of Wisconsin against any such person to enjoin such person from such violation or violations.

147.206 Midwifery. Any person who, on the effective date of this section, is practicing midwifery in this state under a certificate of registration issued him by the board may continue so to practice under such certificate but subject to the provisions of ch. 150 of the 1951 statutes as in effect prior to the effective date of this section and subject to the other provisions of this chapter.

147.21 Penalty. Anyone violating any provision of this chapter shall be fined not less than one hundred nor more than five hundred dollars, or imprisoned not less than sixty days nor more than one year, or both.

147.22 Malpractice. Anyone practicing medicine, surgery, osteopathy, or any other form or system of treating the afflicted without having a license or a certificate of registration authorizing him so to do, shall be liable to the penalties and liabilities for malpractice; and ignorance on his part shall not lessen such liability for failing to perform or for negligently or unskillfully performing or attempting to perform any duty assumed, and which is ordinarily performed by authorized practitioners.

147.23 Chiropractic regulated. (1) No person shall practice chiropractic, or in any manner attempt or hold himself out to do so, unless he have a certificate of registration in the basic sciences and a license to practice chiropractic from the state board of examiners in chiropractic, and shall have recorded such certificate and license with the county clerk of any county in which he shall so practice or attempt or hold out to practice, and pay a fee of fifty cents for each recording.

(2) The governor, with the advice and consent of the senate, shall appoint the state board of examiners in chiropractic to consist of three chiropractors, each of whom shall have been a continuous resident of and practitioner of chiropractic in the state for the preceding three years, who is not an officer or employer, nor financially interested in any school or college of chiropractic, and who shall not be graduate of any school teaching a method of treating the sick other than chiropractic. The term of office shall be six years, and a vacancy shall be filled for the unexpired term. The first appointments shall be made within thirty days after the taking effect of this section, and shall be for terms expiring April 1, 1927, April 1, 1929, and April 1, 1931, respectively. The board shall within thirty days after appointment organize by the election of a chairman and secretary. The compensation of the members of the board shall be ten dollars for each day actually spent and actual and necessary expenses incurred in the performance of their official duties.

(3) Application for a license to practice chiropractic shall be made to the board of examiners in chiropractic, accompanied by sufficient and satisfactory evidence of good moral character, preliminary education equivalent to graduation from an accredited high school of this state, graduation from a reputable school of chiropractic, approved and recognized by the board of examiners in chiropractic, having a residence course of not less than 36 months, consisting of not less than 3,600 60-minute class periods, certificate of registration in the basic sciences, and a fee of $25. An applicant for a license who was regularly enrolled in and attending a reputable and approved school of chiropractic prior to June 1, 1947, or who graduated therefrom prior to that date, shall, if otherwise qualified, be examined on the basis of the requirements of this section as they existed prior to July 27, 1947.

(4) Examination shall be in the subjects usually taught in such reputable schools of chiropractic, and shall be conducted at least twice a year at such times and places as the board shall determine.

(5) The board shall grant without examination a license to practice chiropractic in this state to any person who was on February 1, 1925, a reputable practitioner of chiropractic in this state, and who shall present to the board of examiners in chiropractic, prior to September 1, 1925, sufficient and satisfactory evidence of the same.

(7) All licenses issued by the board shall expire on the thirty-first day of December following the

issue thereof, except that any holder of a license may have the same renewed from year to year by the payment of an annual fee of $8.

(8) The board shall keep a complete record of all applications, examinations, licenses, fees and proceedings. On or before August first of each year, the board shall file with the governor a report of all receipts, disbursements and transactions of the preceding fiscal year.

(9) No person shall practice chiropractic in this state under any other Christian or given name or any other surname than that under which he was originally licensed or registered to practice chiropractic in this or any other state in any instance in which board of examiners in chiropractic shall, after a hearing, find that practicing under such changed name operates to unfairly compete with another practitioner or to mislead the public as to identity or to otherwise result in detriment to the profession or the public. This subsection does not apply to a change of name resulting from marriage or divorce.

147.24 License revocation or suspension. The board of examiners in chiropractic, by order, may deny, suspend or revoke any license or certificate of registration if the licensee or registrant:

(1) Obtained the license or certificate through error or fraud;

(2) Is habitually drunk or addicted to the use of habit-forming drugs;

(3) Is hereafter convicted in a court of competent jurisdiction, either within or without this state, or in federal court, of any violation of any law governing the practice of chiropractic or of any felony, a certified copy of the record of conviction to be conclusive evidence of such conviction;

(4) Has obtained or sought to obtain anything of value by fraudulent representation in the practice of chiropractic;

(5) Is guilty of immoral or unprofessional conduct;

(6) Has continued practice, knowingly having an infectious or contagious disease; or

(7) If the applicant or registrant maintains a professional connection or association with any other person continuing to violate the provisions of this chapter after 10 days' notice in writing by the board.

(8) The board may without further process revoke the license of one who fails to annually register and pay the fee within 60 days after written notice, mailed to his last known address by registered mail. His license may be reinstated, in the discretion of the board, by the payment of $25 within one year from revocation. If application for reinstatement is not made within a period of one year from revocation he may be required to demonstrate that he is still qualified to practice by taking an examination in such chiropractic subjects as may be required by the board. The fee for such examination and reinstatement of license shall be $50.

147.25 Unprofessional conduct. Unprofessional conduct shall include, without limitation because of enumeration:

(1) Any conduct of a character likely to deceive or defraud the public;

(2) Loaning of a chiropractic license or certificate to anyone;

(3) Employment of "cappers" or "steerers" to obtain chiropractic business, or any public solicitation of chiropractic patronage;

(4) Splitting or dividing any fee for chiropractic service with any person except an associate licensed chiropractor;

(5) Use of unprofessional advertising which shall include without limitation because of enumeration:

(a) Any advertising statement of a character tending to deceive or mislead the public;

(b) Advertising professional superiority or performance of professional services in a superior manner;

(c) Advertising fixed prices for variable services;

(d) Using advertising solicitors or press agents;

(e) Use of office signs which contain wording other than the names of duly licensed chiropractors practicing therein, office hours and purely educational matter not in conflict with law;

(f) Use of printed advertisements which contain wording of other than names of duly licensed chiropractors, office hours, location, telephone numbers and educational matter not in conflict with law.

147.26 Procedure for hearings. (1) The board may make investigations and conduct hearings in regard to the conduct of any licensed chiropractor who, it has reason to believe, is acting or has acted in violation of section 147.24 or 147.25. The chairman or secretary of the board may administer oaths and issue subpoenas for attendance of witnesses and take testimony under oath. The person complained against shall have notice in writing of the charges, specifying a date of not less than 10 days after service thereof for a hearing and shall have opportunity to confront witnesses and produce testimony. A stenographic record of the proceedings shall be taken and a transcript made for the board's files. The person complained against may within 60 days after notice in writing to the board's action mailed to his last-known address, by registered mail, proceed to review any action of the board as provided in chapter 227.

(2) Upon application and satisfactory proof that the cause of such revocation or suspension no longer exists, the board, in its discretion, may reinstate any license or registration by it suspended or revoked.

Legal Status of Internes, Externes, and Residents

BEFORE discussing the legal status of internes, externes, and residents, it is first necessary to consider the definition of the terms, as used in Wisconsin. Little help in answering this question can be gained from the Medical Practice Act, Chapter 147, Wisconsin Stats., 1953. The Act makes no mention whatsoever of externes or residents and only briefly refers to internes. The term "interne" is generally understood to apply to one who is engaged in a twelve-months' period of advanced study and apprenticeship immediately subsequent to the completion of his college course and prior to the granting of his license. Section 147.15 makes it a prerequisite for granting of a license to practice medicine and surgery or osteopathy and surgery. The term, however, is sometimes loosely applied to the second and third year following the completion of the required period of interneship, during which similar studies are continued. *But after the first year, unless his medical school requires a longer interneship as a condition of graduation, the interne must be licensed and have the legal status of a practicing physician.* The practical effect of the statutes is to recognize, as within a proper educational sphere, a requirement that a medical student must undertake an interneship as a condition of graduation, but at the moment that the educational requirement of interneship is satisfied the individual is thereupon subject to all the licensure provisions of the Wisconsin statutes. In this discussion then, "interne" will be limited to those in the first year of interneship.

The term "externe" is professionally applied to those advanced medical students *who have not as yet reached the interne stage, or been licensed to practice medicine*, but who are performing certain assisting and observing functions, either during a vacation period or during their fourth year of medical study, under the supervision of a licensed physician. Externes enter into this course of training under an arrangement between supervising physicians and the medical school. The hospital has no jurisdiction over them.

The term "resident" is generally applied to postgraduate medical students who have completed their required year of interneship and are doing what really amounts to advanced interneship work.

It is apparent then, that neither externes nor internes have the full legal status of licensed practitioners. Accordingly, the scope of their functions is correspondingly more confined. Their legal status has never been specifically passed upon by the courts, nor has the legislature seen fit to define their powers and duties, the matter being left entirely in the hands of the medical profession.

That an interne has certain functions of a medical nature which he is permitted to perform is recognized by the Wisconsin Supreme Court, in the case of *Nickley v. Eisenberg*, 206 Wis. 265. The court there admitted that internes are not subject to the Medical Practice Act, because the Wisconsin statutes require an interneship as a part of one's medical education prior to licensure. The court summarized the legal status of an interne in Wisconsin as follows: "This is a legal sanction of the performance of such duties on the part of internes as are usually and ordinarily performed by them. The performance of such duties does not constitute the practice of medicine or a representation that the interne is authorized to practice medicine." In the same opinion, the court recognized the legal status of certain nurses who were not registered under Chapter 149. By the same reasoning, externes would probably have a recognized status in the medical profession. But their status is such that neither internes nor externes are within the provisions of the so-called "Medical privilege statute" under the case of *Borosich v. Metropolitan Life Insurance Company*, 191 Wis. 239.

The further question arises as to those responsible for mistakes made by internes or externes while performing their customary duties. That they are personally responsible for their negligence is, of course, conceded, and this liability may extend to physicians under whom they are working or to the hospital employing them. The law generally holds the interne to be an employe or servant, inasmuch as he is obliged to spend his days and nights at the hospital to render any administrative or medical service provided by the hospital through its agents within the range prescribed by propriety and custom. This interpretation of his position is recognized by the courts under the workmen's compensation act, which extends employe protection to internes injured in the performance of their duties in the hospital.

Wisconsin has held that the hospital is responsible for liability arising out of the acts of internes in the performance of duties which are customarily performed by them. Exemption, however, has been made in the case of charitable hospitals which are protected by law for the acts of their employes or servants. A similar exemption is made for state and municipally owned hospitals, except where the patient involved is a private patient receiving care at his own expense. See *Schumacher v. Evangelical Deaconess Society*, 218 Wis. 169; and *Carlson v. Marinette County*, 264 Wis. 423. However, where the interne is acting under the direct supervision of a physician or surgeon during the course of an operation, the hospital is absolved from responsibility and his acts become those of the surgeon or physician who has charge of the work.

An externe, as was pointed out, is generally an assistant of a physician and has no relationship to the hospital. Because the duties delegated to an externe by a physician are generally very much limited, extending only to observation, a situation would seldom arise in which an act of an externe might cause injury. A physician would presumably have the duty to see to it that the externe be delegated no duty which would call for discretion or judgment on his part, but should he be negligent, the responsibility for his acts would doubtless be that of the physician.

A "resident" in an institution or hospital, is required to hold a license to practice medicine (26 Opinions Atty. Gen. 504) and is as fully responsible for his acts or omissions as any other practitioner.

Medical Partnerships

Introduction

WHEN two or more physicians decide to be associated with one another, such association takes one of three forms. Under one form, one of the physicians, usually the older, employs one or more other physicians on a salary, or a combined salary and bonus basis. A second form of association is one under which two or more physicians share the reception room and laboratory facilities, as well as clerical staffs, on an agreed basis, but each retains the full earnings of his professional practice. The third, and most intimate form of professional association, is the partnership. Under such an arrangement, two or more physicians agree to share the profits and losses and the other ups and downs of their pooled professional efforts.

Practice in the form of a corporation has been excluded from consideration here because of the well established legal principle that a corporation cannot practice medicine. Accordingly, a corporate organization in the medical field usually is limited to the ownership of land, building, and equipment which may be leased or otherwise made available to two or more physicians. Those complications represent a separate subject which does not properly fall within the scope of this article.

Nature of Partnership; Some Disadvantages

A partnership is one of the closest forms of personal and legal association which exists. On the legal side, inasmuch as each partner is held by law to be an agent of the partnership, he may bind the partnership by his actions, which is another way of saying that he may bind all other partners. That is especially true of a state like Wisconsin, which does not regard the partnership as possessing legal entity or personality, such as characterizes a corporation. The law of this state regards a partnership as nothing more than an aggregation of two or more persons. Such action by one partner may be nothing more than the decision to subscribe to a magazine or to purchase a new piece of equipment. In another situation it may also involve his partners in alleged liability for negligence in the treatment of a patient.

Further, the partnership assets are subject to the rights of the creditors of each partner for obligations incurred by that partner in the conduct of partnership's activities. Such creditors, having established their rights, may proceed against the full partnership assets should that be necessary to satisfy such rights.

Clearly, there are substantial professional personal and financial risks implicit in the partnership relationship.

Some Advantages of a Partnership

One of the principal advantages of a partnership is that it permits the pooling of professional skills, of separate backgrounds, and of the power of different types of men to attract patients. In the practical financial aspect, a partnership permits the pooling of capital. It also serves as a cushion against losses to have one or more persons share those losses. Where all but the owner of a practice are on a salary basis, such owner has to carry losses alone.

A further marked advantage of a partnership arrangement is the relatively greater stability of professional practice which this type of association makes possible. Not only is consultation likely to be freer while all partners are there, but there is greater likelihood of continuity when a partner is absent for any cause, or when he retires or dies. This factor of continuity is advantageous alike to the patient and physician. A partnership can build its practice at certain standards with greater assurance than is probably possible in other types of association, that such standards will be continued during the absence or following the withdrawal or death of one or more partners.

On the economic side, disposition of a practice can be more flexibly arranged through a partnership than through other means. The conclusion seems warranted that the reasonably assured advantages of a partnership substantially outweigh its potential disadvantages.

Establishment of a Partnership

A partnership may in fact exist by consent and understanding between the partners, even though the fact is not known to the general public. It may also exist by oral understanding, or by operation of law, even where there is no formal agreement. The first arrangement might have possible ethical considerations. The second type is clearly imprudent on tax and other financial grounds. Every partnership between professional men for the open practice of

their profession on an association basis should be openly and publicly declared. Further, every such association should, for the protection of the parties during life, and for the protection of their estates and families on death, be formalized in a written contract.

Advantages of a Written Partnership Agreement

It is entirely possible for two reasonable individuals who are dealing with each other on a verbal basis to misunderstand each other. No contract can be written which will cover all situations. or remove all such possibilities. Areas of potential misunderstanding can be greatly reduced, however, when the intention of the parties on basic matters is put in writing. Such questions as name and the right of its continuing use; the inclusion or exclusion of such intangible factors as good will; the valuation of tangible assets and of accounts receivable, either of which may vary substantially from those shown on the partnership books; the share of each partner in the capital of the partnership; the share of each partner in the gains or losses of the partnership, which again, may vary substantially from his capital investment, all these, and many other points may be covered, and are ordinarily settled by a competently drafted partnership agreement.

Termination of Partnership

Ordinarily, a partnership between physicians is dissolved on the withdrawal or death of any of the partners. A partnership agreement may provide, however, for the continuation of a partnership in either contingency. Thus, the retired partner may continue to enjoy the fruits of his efforts on at least a limited basis during the period required for collecting his accounts and winding up his interest.

In like manner, the widow and children of a deceased partner may, through contract made while the physician was alive, avoid the disadvantage of a forced liquidation. This ordinarily will permit a greater total payment to the retired physician, or to the heirs of a deceased physician, than is possible from an immediate sale or other liquidation of his interest. It also permits a substantial tax saving to the surviving partners under the present provisions of the federal income tax law.

The tax advantage above mentioned has a rather technical basis which can be summarized with substantial accuracy as follows: Where a partnership agreement makes no provision for the sale of the interest of a retired or deceased partner, the purchase of such interest by the remaining partners is not deductible by them for income tax purposes, but has to be capitalized. Only those portions of such capital investment as are depreciable can be written off during the useful life of such assets.

On the other hand, where an inactive or deceased partner has a continuing participation in the net income of a partnership for an agreed period, such income is reportable and taxable as to him or his heirs as ordinary income, rather than as capital gain or loss. All such payments are *deductible* from the net partnership income of the remaining active partners. Generally speaking, the inactive partner or his heirs suffer no substantial tax disadvantage under such an arrangement; whereas, the living partners enjoy a substantial tax advantage by reason of which they can pay more for such interest than would otherwise be the case.

Basic Provisions of a Partnership Agreement

Following is a list of basic provisions which should be carefully worked out and inserted in a partnership agreement. Accompanying them are brief comments either to indicate the importance of the provision, or advice as to its phrasing.

1. *Name and Purpose.*—The name should be chosen carefully, and will frequently bear the names of two or three partners (seldom more), or of the community. If the name of one or more partners is used to designate the professional firm, the contract should provide whether the right to continued use of such name is to survive the retirement or death of such partner.

2. *Location.*—The locality in which the partnership proposes to practice should be set out specifically. If the partners conclude that they wish to insert into the contract a covenant limiting the right of a withdrawing partner to engage in practice within a particular area for a particular time, this should be done carefully in the body of the agreement. It is also necessary that the area limited and the time provided in such case be reasonable under all the circumstances.

3. *Duties of Partners.*—The agreement should set out with care whether the partners are to give full or part time to the affairs of the partnership, and to provide any limitations on possibly conflicting other professional activities, or on non-professional activities.

4. *Managing Partner.*—It is frequently advisable to designate a managing partner. This centralizes authority for purchasing, for making financial decisions, and for establishing essential supervision over nursing, technical and clerical staffs. It may be desirable to rotate the management so as to give all partners such experience over a period of time.

5. *Initial Valuation of Partnership Assets.*—It is important that the agreement designate carefully just what assets are included in the initial capitalization of the partnership. Such tangible assets as professional library, equipment, and cars are relatively easy to evaluate. Good will should not be included if, upon retirement or death of a partner, the partnership wishes to deduct payment therefor in arriving at distributable net income to the remaining partners. On the other hand, it should be included if the retiring or deceased partner's heirs wish to treat payment therefor as capital gain.

6. *Capital Investment.*—The agreement should set out carefully the percentage of interest of each partner and the amount of capital to be paid by him; also which interests have been paid for, or partially so. Any partnership interest not wholly paid for should be the subject of carefully worked out business arrangements. The most common of these is the giving of a note without interest, or at a low rate, to be paid the lending partner or partners by the borrowing partner out of the latter's annual share of net partnership profits.

7. *Sharing and Definition of Expenses.*—While it might seem too obvious to insert, it has been found good practice for the contract to make it clear that all partners agree that expenses shall have the first claim on partnership gross earnings, also what items are to constitute such expenses.

8. *Sharing of Profits or Losses.*—The share of each partner in the net profits and losses of the firm should also be set out with care. This may, but need not be the same percentage as the interest of each partner in the capital structure. A younger physician, for example, might have the same financial investment in a medical partnership as an older partner, but be less productive of professional income. Ordinarily, the younger partner would not have the same drawing power. Such differences can be reflected by agreement as to the extent of participation of each partner in the net profits or losses of the firm. As a matter of law, the sharing of profits or losses is perhaps the most fundamental single test in determining whether a given association is a partnership or something else.

9. *Partnership Drawings.*—The actual financial outcome of a partnership year obviously cannot be determined until the year has ended and the books have been closed. The usual practice is to establish drawings for each partner which are the monthly distribution of estimated profits. Minimum salaries may be established which can be treated as expense by the partnership. It is a prudent practice to establish aggregate drawings at not over 85 to 90 per cent of estimated net income. This allows the partnership to maintain a desirable working capital and to establish some savings for year end distribution or for periods when one or more of the partners are ill.

10. *Distributed vs. Distributable Shares.*—The problem in this field may be best illustrated by example. Assume that the share of Doctor X in the net cash income of a medical partnership for a particular year was $20,000. Assume during that year he had drawn $1,500 a month, or a total of $18,000. The latter figure of $18,000 is the *distributed* share, namely, what he actually got. The figure of $20,000 was his *distributive* share, or the one to which he was entitled on a bookkeeping distribution of the net earnings when the books for the year were closed.

Doctor X can draw or retain in the firm the $2,000 as soon as it has been determined that he is entitled to that extra amount as the balance of his share of profits for the year. He must, in any event, report that higher figure for *both* federal and state income tax purposes, whether he draws it out of the firm or leaves it there.

Conversely, if Doctor Y of the same firm drew $1,000 a month during the year, or a total of $12,000, and his *distributive* or earned share was found at the end of the year to be only $10,000, he would owe the firm the sum of $2,000. This is the excess of the *distributed* or estimated advance payment to him over what was ultimately determined to be his true or *distributive* share. He would report for income tax purposes not the $12,000 which he drew through erroneous estimate, but the $10,000 to which he was entitled by the terms of the partnership contract.

This point should be covered in the agreement.

11. *Vacation and Postgraduate Study.*—It is advisable to establish by formula the period of vacation of each partner. It is common to do this on a basis of the length of time a partner has been a member of a particular firm, or a predecessor firm in the same community. Agreed vacations are known to vary from a minimum of two weeks to as much as three months in this state.

In like manner, it may be advisable to provide by contract for the allowance of time needed for postgraduate studies, or for participation in affairs of professional medical organizations, should it be anticipated that one or more partners will desire or require a substantial amount of time for such purposes.

12. *Illness of Partner.*—On this important subject, four points may be emphasized. The first is that a medical partnership is generally collecting past due accounts. Thus, the financial impact caused by the sustained illness of a partner is not felt at once. Second, there is a difference between partial and total incapacity. Third, there is a great difference between temporary and permanent disability, whether partial or total. It is well for a partnership agreement to provide the financial arrangements which are to control during the illness of a partner. Any such arrangements should take any of the three above factors into account.

A fourth factor is the amount of disability or time loss insurance which the partnership may carry for each of its members, or which the members may carry as items of personal expense. The premiums of such policies are not deductible for income tax purposes; neither are payments to physicians under such policies includable in gross income.

Following are typical arrangements made to cover the illness of a physician partner:

(*a*) If the illness or incapacity is partial, and does not extend beyond six months, no reduction is made in drawings.

(*b*) If such partial incapacity continues beyond six months, an adjustment in such partner's financial participation in the firm is to be negotiated which will recognize the extent to which he can practice his profession.

(*c*) If the illness or incapacity is total, maintain

established drawings of such partner in full up to six month maximum.

(*d*) If such total incapacity continues beyond six months, reduce such financial participation by degrees, so that after 18 months, for example, the remaining partners could dissolve the firm, or make other arrangements suitable to them. Established drawings of such a partner might also be reduced after six months by the amount of his payments under disability or time loss insurance, up to an agreed figure or percentage.

13. *Withdrawal, Retirement, or Death of a Partner.*—Of all the problems faced by a partnership, there are probably none which are more difficult to evaluate and to solve by contract than the related problems of withdrawal, retirement, or death. As used in this connection, "withdrawal" means the optional leaving of a partnership, irrespective of cause other than health. "Retirement" is limited to the leaving of a partnership on grounds of health.

On consideration, it would seem rather evident that where a partner is withdrawing from a firm because the other partners wish it or because he desires to practice elsewhere, there are elements of dealing at arm's length and of individual judgment and volition which are lacking in the other two situations. Further, there is a far greater element of individual judgment and of negotiation possible upon retirement for health reasons than there is with an estate or heirs following death.

Some medical partnerships are beginning to reflect some of the above factors in the financial settlements made where a partner leaves a firm. Ordinarily, the settlement will be smallest where a partner *withdraws;* it will be more generous where a partner *retires* for reasons of health; it will be most generous where a partner *dies* without having withdrawn or retired. The legal and tax considerations of such arrangements call for careful draftsmanship if the wishes of a partner and the maximum advantages of such arrangements are to be assured.

14. *Insurance.*—The partnership agreement should consider at least two types of insurance. The first is what insurance is to be carried by individual partners. This would ordinarily include individual malpractice and car insurance. The minimum limits of such policies should be set out in the agreement, or left in the discretion of the managing partner. It may also include minimum amounts of disability or time loss insurance.

The second type of insurance is that to be carried by the partnership, generally as an expense. This would include public liability on the premises of the partnership; partnership malpractice insurance covering the potential liability of all partners for the professional acts of any one of them; workmen's compensation and employer's liability; fire and extended coverage on equipment and library of the partnership; rental or similar insurance to cover special expenses in connection with loss due to fire or other casualty, non-ownership automobile and hired car insurance; comprehensive coverage on the cash and securities of the partnership, including wrongful loss or mysterious disappearance.

If the partnership concludes to carry disability or time loss insurance on its partners, this can be handled by the partnership as a matter of convenience, but it should be charged to the individual drawing accounts of the partners, since such premiums are not deductible for income tax purposes.

A third class of coverage, although not treated in the partnership agreement, is life insurance, which the partners carry on the lives of each other. Thus, if Doctors X, Y, and Z were partners, and each of them was insurable, it is a common practice to provide by a *separate* contract, wholly independent of the partnership agreement that Doctors Y and Z will insure the life of Doctor X and pay the premium thereof in agreed ratios, and that Doctors X and Z will do the same for Y, and Doctors X and Y will do the same for Doctor Z.

The above arrangement can also be handled through a trust agreement, although this is needlessly cumbersome and costly unless a large insurance program is involved. While premiums on such policies are not deductible as expense, the receipt of insurance proceeds by the surviving doctors is not taxable as income. Neither are such insurance proceeds taxable to the estate of the deceased doctor where he did not own or control the policy.

The life insurance, instead of being carried and owned by the other partners on the lives of each other, could be carried and owned by the partnership and the premiums treated as business expense of the partnership for all purposes other than income tax deductibility.

15. *Professional Records.*—It is well for a partnership agreement to provide what disposition is to be made of case histories and other professional records in the event of retirement, withdrawal or death of a partner, or dissolution of the partnership.

16. *Dissolution.*—If an agreement is silent as to dissolution of a partnership, the Wisconsin statutes control. Where special arrangements are preferred by partners, it is believed desirable that this subject be spelled out in the partnership agreement.

1954 Revenue Act Changes

The 1954 Revenue Act allows the various partners comprising a partnership to allocate among themselves the amount of capital gains and losses, charitable contributions, tax-exempt interest, dividends received, and the like, provided the purpose of such agreement among the partners is not evasion or avoidance of income tax. In other words, if there is a good reason for allocating one of these types of income to a particular partner, other than tax avoidance, the Revenue Code now permits this to be done.

Likewise, the partners may now agree among themselves to allocate the amount of depreciation allowable. For example, a partner may have contributed an asset which cost him $500 but which has been treated as having a value of $1,000 for pur-

poses of computing his contribution to the partnership. Assume that the other partner has contributed $1,000 in cash. In effect, this other partner has purchased a one-half interest in the property contributed by the other partner; and if it is assumed that the asset valued at $1,000 for partnership purposes is depreciated over a 10-year period, the other partner should theoretically be entitled to a depreciation allocation of one-half of $100, or $50. This can now be done by express agreement between the partners. In the above situation, all of the depreciation allowable to the partnership would be passed on to the other partner to the exclusion of the contributing partner.

The new Code treats a guaranteed salary paid to one of the partners as deductible by the partnership and includable in the income of the partner who receives the salary, even though the salary might exceed what he otherwise would have been entitled to, based upon his percentage of participation in partnership profits.

Payments to a retired partner or the heirs of a deceased partner in the form of continued participation in the partnership profits for a period of years has now been made definite by the new law. Actually, the new law codifies what was enunciated by the courts in interpreting the previously incomplete partnership tax statute. The new statute provides that payments made to a retired partner or a deceased partner's heirs are to be treated by the recipient as ordinary income and are deductible by the partnership except to the extent that such payments are made in liquidation of his capital interest and in payment for good will when such payment for good will is expressly provided for in the partnership agreement. The new law permits what was previously somewhat doubtful; namely, the payment of a guaranteed lump sum, as contrasted with a percentage of the profits of the continuing partnership. In other words, under the new law, the retired partner or deceased partner's heirs can be paid an amount such as $10,000, and have this deductible by the partnership and reportable as income by the retired partner or a deceased partner's heirs. It is not necessary, therefore, to gear the post-retirement and death payments to the profits of the continuing partnership.

The new Code provides that henceforth partnerships may not adopt or change to fiscal years other than ones coinciding with the taxable year of the partners. This provision does not affect existing partnerships having fiscal years different from those of its partners.

The new law makes substantial changes regarding the partners' income tax basis of assets received in a partnership distribution. In the case of a distribution to a partner, other than in liquidation of his partnership interest, his income tax basis for property so received from the partnership shall be the same as the basis of the asset in the hands of the partnership immediately prior to the distribution. In no case, however, may the basis of property distributed exceed the basis of the partner's partnership interest reduced by the amount of money distributed to him in the same transaction.

For example, if partner A has a basis of $10,000 for his partnership interest, and he receives as part of a non-liquidating distribution, cash of $4,000 and property with a basis to the partnership of $8,000, the basis to partner A of the property other than the cash is $6,000 ($10,000 minus $4,000).

If property is distributed by a partnership to a partner in complete liquidation of his interest, his basis in the distributed property shall be an amount equal to the adjusted basis of his partnership agreement reduced by any money received in that transaction. The adjusted basis of his interest in the partnership shall not include an allocation for unrealized receivables and inventory items unless the partnership had an income tax basis for these assets. In the case of most cash basis partnerships, the partnership will have no income tax basis for these items.

Upon the liquidation of a partner's interest in the partnership, the partner whose interest is liquidated may, in certain instances, take advantage of an optional allocation of his basis. This, however, is a technical matter. Likewise, the partnership may elect to have the basis of its remaining assets adjusted when distributions of property are made to a partner. Again, this is a technical matter. Upon the occurrence of a distribution of property to a partner, it is suggested that competent legal and accounting advice be sought.

Conclusion

Few personal or professional decisions are more important in the life of a practicing physician than that of entering into a partnership. It is necessarily an intimate relation at professional, financial, and personal levels. It should not be entered into lightly, or with undue haste. Each partner should know the professional qualifications, the character, and the habits of the other. Personal congeniality is highly desirable because of the inevitable closeness of the working arrangement.

Once the above considerations have been duly weighed, the matter should be carefully discussed with an attorney. If the latter should not be familiar with certain of the ethical and other considerations which distinguish medical practice and which should carry over into medical partnerships, the physicians should inform their attorney on such points. It is also believed prudent, in terms of time saving and tax saving, to have partnership books established and periodically audited by a certified public accountant.

Partnerships which are entered into with the care above indicated and recommended should have a correspondingly greater likelihood of successful operation and survival.

Fee Splitting

Introduction

SINCE 1913, the Wisconsin statutes have forbidden fee splitting by physicians. See Section 343.322 of the statutes. Likewise, the profession itself has long frowned on the practice, as has the American College of Surgeons in its *Manual of Hospital Standardization,* published in 1946. At page 19 is set forth "Principles of Financial Relations in the Professional Care of the Patient." This statement of principles makes it very clear that the practice of fee splitting is deemed professionally undesirable even in those states which do not specifically prohibit it. Further, the Manual has as a part of its requirements the adoption by each hospital of a resolution against the practice in which must join all physicians who have hospital privileges. Fee splitting is unreservedly condemned, and a hospital in which this practice is known to exist cannot secure or retain a place on the approved list.

It has been said that fee splitting actually means "the buying and selling of patients on a commission basis." The direct effect of fee splitting is that the patient is deceived into thinking that the statement rendered by the physician is for services rendered by him alone. In fact it might include a fee for forwarding the patient or for services rendered by one or more other physicians. The vice is not so much that the patient pays more when the fee is split, but that he does not know all of the parties whom he is paying. Of course, the practice lends itself to overcharging the patient when the splitting of the fee is made as a reward for sending the patient to the physician who actually does the work.

In 1914 the attorney general, Hon. Walter C. Owen, later a member of the Wisconsin supreme court, was asked for an official opinion interpreting the fee-splitting statute and indicating its effects. Below are stated the eight questions which he was asked to answer, together with a summary of his opinion which appears in volume 3 of the *Opinions of the Attorney General of Wisconsin,* at page 218. This opinion was approved and reaffirmed by a later attorney general in 1935. (See volume 24, *Opinions of the Attorney General of Wisconsin,* page 580.)

Attorney General's Opinion

1. *Under the law as it now stands, can a surgeon, not a member of the regular staff of a hospital, operate at such hospital for a stated fee for the institution and let the hospital collect the surgical fee from the patient according to his ability to pay along with other hospital fees; the hospital paying the surgeon the fee agreed upon, whether larger or smaller than the fee charged the patient by the hospital, or must the surgeon, under the circumstances, charge the fee for the operation direct to the patient?*

While the law does not specifically make it an offense for a hospital to employ a surgeon who is not a member of its regular staff to perform a particular operation under an arrangement that the hospital make its charge to the patient for such operation or treatment and that it make its charge for such surgical services irrespective of the amount paid by it to the surgeon, yet it would seem that the evils incident to such a practice would be as great as in the case of fee splitting between two physicians or surgeons.

2. *Where a surgeon operates at a hospital in which he has a financial interest, or in which he is part owner or sole owner, but conducts the business in the name of the hospital, must he make a separate charge for operation or may the whole charge be made by and in the name of the hospital?*

The hospital may employ a physician or surgeon upon salary and then make a contract with the patient to furnish him both medical or surgical treatment and hospital service. If this is done, the entire charge could be made in the name of the hospital. If, however, the physician or surgeon is not paid a salary, but charges separately for each treatment or each operation, the safer practice is to make the charge for medical services direct to the patient and let the hospital make its charge separately to the patient.

The attorney general was asked in the same opinion to answer the three questions which follow, and in each case did so with the statement that the safer practice under any of the above circumstances is for the surgeon to make his charge *direct* to the patient, or to phrase it otherwise, for the *consulting* surgeon to make a contract with the patient which is separate from that between the *original* physician and the patient.

3. *Can a surgeon who is not a resident of the city where the hospital is located and who does not hold himself out as a member of the staff of such hospital operate at such hospital and make a charge direct to the hospital under the existing law?*

4. *Where a country physician engages a surgeon to assist him in an operation at the home of the patient or at the residence of the country physician, can the surgeon make his charge direct to the country physician engaging him or must he make a special contract with the patient?*

5. *Under these conditions, can the country physician make the contract with the surgeon or must the contract be made directly with the surgeon by the patient?*

The attorney general was also requested in this opinion to answer the three remaining questions set out below, and again stated as his opinion that the physician's and surgeon's charges should be made

direct to the patient and that no part of the fee received by the surgeon or hospital should be paid to the physician advising the operation or treatment.

6. *Is a physician who brings a patient to a hospital for an operation or to a surgeon for an operation entitled to a fee for assisting in such operation or for time spent in accompanying the patient to the hospital or place of operation?*

7. *Can a surgeon charge a regular fee for operations to a physician, including fee for operating room, dressings, anesthetic, etc., irrespective of the ability of the patient to pay, and the physician in charge of the case collect his fee, including such operating fee as he thinks right, the surgeon performing the operation doing the work for and on contract with the physician?*

8. *If the surgeon or hospital charges a regular fee for operation to physicians, must the same fee be charged to patients who come for operation not accompanied by their physician, or can the surgeon or hospital make a charge suited to the ability of the patient to pay?*

While the attorney general's opinion does not have the same authoritative standing as a decision of the state supreme court, for example, it is important as the official expression of the highest non-judicial legal officer of the state, and both the courts and the legislature have in many cases accorded substantial standing to such opinions.

Effect on Partnerships and Clinics

Although there is no law on the matter in Wisconsin, and the attorney generals' opinions have not thus far ruled on the point, it is believed that the statute, as phrased, does not forbid the formation of medical partnerships and clinics, or the rendition of a *single* bill for services performed by more than one physician in either organization. It is believed that this is a *permitted exception* to the fee-splitting statute even though two or more physicians in a given partnership or clinic may have rendered services to the same patient in connection with the same general examination or ailment. That is believed to be the *only* exception, however, contained in the Wisconsin statute, and the probable reason for it is that the factual arrangements between two or more physicians in a partnership or clinic are open and generally known instead of being concealed and indeterminate. A secret partnership formed to evade the fee-splitting statute is undoubtedly in violation of that law.

LIQUOR PRESCRIPTIONS

The friend may be penny wise, but the physician is pound foolish who prescribes for the friend's thirst or do-it-yourself proclivities rather than for his health. The friend will have the pleasure of his potion and perhaps the joy of a tax saving. But the physician will be subject to a fine of from $250 to $1,000 and to imprisonment for up to six months. If convicted twice, his license to practice may be revoked.

Section 176.19 of the Wisconsin Statutes imposes the above penalties for prescribing intoxicating liquors beyond what is necessary for health if done with intent to evade tax or license requirements for the sale of liquor.

POSTMORTEM EXAMINATION

A great deal of confusion always existed about whose consent was required to permit a physician to conduct a postmortem examination with impunity. Sometimes the next of kin was not immediately available, or there were several persons of the same degree of kinship. The physician who performed such an examination without proper written consent did so at considerable personal risk.

Now, under Section 155.05, Wisconsin Statutes, consent for a physician to conduct a postmortem examination is sufficient when given by the person who assumes custody of the body for burial, providing he is the father, mother, husband, wife, child, guardian, or next of kin. If none of these are available, consent may be given by a friend or person charged by law with responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Medical Witnesses and Expert Testimony

Introductory

NEVER before has medical testimony assumed such importance as in recent years. Formerly many medical men asserted that they did not care to be drawn into litigation, but it is now next to impossible for an active general practitioner, much less for a specialist, to escape at least some appearances either before courts or such administrative tribunals as the industrial commission. Medical testimony is important and frequently even of controlling weight in cases involving mental competence as, for example, lunacy, guardianship, and will proceedings. It is also of paramount importance in the field of industrial accidents and disease, while the increased use of the automobile has in itself given rise to an almost independent branch of jurisprudence and with it problems of forensic medicine.

The subject falls logically into two divisions. The first is that of the ordinary nonexpert medical witness, and the second is that of expert or opinion testimony ordinarily offered only by specialists. A number of observations may be made with equal applicability to both classes of medical witnesses.

Duty to Testify

One of the first questions which arises in the mind of the physician is his duty with respect to offering testimony either in a nonexpert or expert capacity before a court or administrative tribunal. It may seem an elaboration of the obvious to recall that the physician is first of all a citizen and as such an integral part of his community; that the courts and such bodies as an industrial commission "are part of the machinery of his government." The average physician undoubtedly has a professional duty to assist, with his training and knowledge, a judge or public administrator who may have need of his judgment. This is quite apart from any legal requirement.

On the purely legal side it is well settled in Wisconsin, as elsewhere, that a doctor must obey the order of a court or other properly authorized public official to appear and offer testimony in a given case. This order customarily takes the form of a subpoena and the doctor must obey a subpoena, just as any other citizen, under penalty of contempt.

Medical Privilege

Both the nonexpert and expert medical witness must remember at all times that Section 325.21 of the Wisconsin Statutes makes privileged any information which the physician may have acquired in attending any patient in a professional capacity, necessary to enable him professionally to serve such patient. See "Physician, Patient, and the Professional Secret," page 41. The only exceptions are: homicide trials, lunacy inquiries, civil or criminal malpractice actions against the physician, and express waiver of the privilege either by the patient, or in the event of the latter's death or disability, by such person's personal representative.

I. NONEXPERT TESTIMONY

General Scope

Generally speaking, the testimony of an ordinary practitioner appearing in a nonexpert capacity is much more limited in character than that of his brother physician who has qualified and is appearing as an expert. Ordinarily, the general practitioner may testify only to what he has observed in the case of a given patient and a given disease. He is limited to the facts which have come from his own professional diagnosis and observation, although even the nonexpert medical witness generally is given a latitude unknown among nonexpert witnesses in other fields, that of prognosis. This undoubtedly is judicial recognition of the high general training of the medical profession, and of the further fact that a physician is as greatly concerned with prognosis as with diagnosis and treatment. No medical witness whether nonexpert or expert should ever volunteer an answer to a question to which he does not know the answer. Neither should he fall into the trap of giving an opinion which exceeds either his training or his observation.

Preparation

While no conscientious physician will venture before any tribunal unprepared, unless summoned without notice, it may be said as a general proposition that exhaustive preliminary research either in the laboratory or in medical literature is not to be expected in the case of the nonexpert witness. It is ordinarily enough that he review his case notes, hospital record or other memoranda, and limit himself to what they show, together with such other findings as are within his personal knowledge.

Neither the nonexpert nor expert medical witness may employ medical texts to supplement his testimony. It is permissible in some states to quote medical authorities who agree with the findings of the witness, or for the witness to state that his diagnosis or prognosis is supported by a certain medical writer. But in Wisconsin, quotations from medical authorities may be used only if not objected to by the opposing party. With the possibility that objection might be waived, however, it is undoubtedly advisable for any physician before going into court to have in mind at least the leading literature of the particular field in which he is going to testify, unless it is so highly limited that only a specialist could be expected to know it. By having that min-

imum preparation he may be saved the embarrassment of seeming unfamiliar with outstanding medical literature, which admission is frequently elicited by the attorney for the other side for the sole purpose of casting doubt on the validity of the witness' otherwise competent testimony. Wisconsin law offers the witness protection against this kind of impeachment, but only if the witness had not earlier referred to authorities in support of his testimony, and if formal objection is made to the opposing attorney's tactics. Even in Wisconsin, then, familiarity with the authorities is the better insurance against embarrassment; the protection afforded by the law will not always be available.

Compensation

The question of the compensation of the nonexpert witness rather commonly arises, and is a matter which should be settled, wherever possible, in advance of the physician's appearance before a tribunal. As a matter of strict law neither a nonexpert nor expert witness is, merely in his capacity of witness, entitled to more than the statutory fee, which in Wisconsin is $2 per day before a justice of the peace or city, town, or village board or committee, and $5 per day before a court of record of any other board or committee. Travel within the state to and from one's residence is reimbursed at five cents per mile. If a nonexpert witness is to receive more compensation than is given him by law, this should be arranged for with the person requesting such witness' public attendance and testimony. It is reasonable for the nonexpert general practitioner to ask compensation, within the financial limits of the party on whose behalf he appears, which will roughly compensate such witness for the loss of time and inconvenience to which he is put.

Care should be observed, however, in the interests of the physician's own integrity, and in the best interests of justice, that the physician at no point acquire a monetary interest in a given piece of litigation which might even unconsciously color his judgment. While no exception can be taken to a physician's testifying as favorably as he conscientiously can for the particular side on which he is called, the ethical physician will be careful never to have a vested interest in the outcome of a pending case.

II. EXPERT TESTIMONY

General Scope

The general subject of expert or opinion testimony is the peculiar province of the expert witness. In the words of a recent author on jurisprudence: "An Expert Witness is one who has made the subject upon which he gives his opinion, a matter of particular study, practice or observation, and who has a special knowledge on the subject, which must be recognized in law as a distinct department of human knowledge and endeavor."

The Wisconsin Supreme Court, in a leading case on the subject, states: "*The more difficult field is entered when we approach the question of calling upon men of exceptional experience and qualifications to give their opinion as the result either of facts which they observe or from an hypothetical statement of facts. This is the real field of expert evidence. It is there that the expert can testify and the nonexpert cannot.*"

Meaning of "Expert"

At the outset care should be taken to distinguish two senses in which the word "expert" is commonly used. As the Wisconsin Supreme Court has wisely observed, "Much of the testimony of a so-called expert is in no wise different in character from that of any other witness." Frequently both attorneys and courts seem to regard *all physicians* as expert in the general field of treatment of human illness by comparison with laymen. It is true that all physicians are expert in the sense of being peculiarly and specially educated in the general subject of medicine. The situation is further complicated by decisions holding that, although a physician is not a technical specialist in a particular branch of medical science, he may testify as an expert, where, assuming hypothetical statements of fact to be true, he can express an opinion, satisfactory to himself without further study, as to a question of science pertaining to a special field.

Perhaps the principal difference between an expert and nonexpert medical witness is that the former's testimony is far less circumscribed. The nonexpert is limited to matters within his personal observation and knowledge. The nonexpert may not ordinarily express an opinion, as differentiated from facts, except in the field of prognosis. The expert, on the other hand, may, in addition to stating observations and other facts within his personal knowledge, give opinions based on two sources other than professional observation of the party as to whom he is offering testimony. These are: (1) Information gained by him from testimony which the expert heard in court; (2) Information assumed by a hypothetical question propounded to him.

Qualifying Physician Expert

Whereas the general practitioner is ordinarily qualified with the statement that he has been admitted to the practice of medicine in Wisconsin, and that he has practiced for a given number of years, the expert must be qualified far more carefully. He should make statements as to his postgraduate studies, his research, any writings, any teaching or other positions, any specialized experience or practice, the fact that he has had opportunity to observe an exceptionally large number of cases, or anything else designed to set him apart from the general practitioner or nonspecialist. The special background of the witness, of course, will be impressive to judge or jury; but its legal importance is to "qualify" the witness as an expert; that is, to establish him as competent to give an opinion and to define the areas in which his opinion has weight.

Moreover, in order to qualify, at least before Wisconsin courts, his expertness must be founded at least in part on his personal experiences and observations; reading alone won't do.

When Expert Opinion Warranted

As has already been stated it is equally the duty of the expert as well as the nonexpert medical witness to respond to a properly issued summons to appear before a tribunal. This rather fundamental difference may be noted, however, between the expert and nonexpert witness. The essence of the nonexpert's testimony is *facts* and *actual observation*, whereas the essence of the expert's testimony is *opinion* based upon a special skill and experience even in the absence of observation of a given case. A nonexpert witness would undoubtedly be in contempt of court for refusing to tell what he *knew* in a given case especially where the patient has waived the statutory privilege, but a court cannot compel an expert to have an *opinion* concerning a situation of which he has not personal knowledge, or as to which he has made no observations. However, if the expert does have an opinion, whether previously familiar with the case then before the tribunal, or not, he is under legal duty to offer that opinion if so requested. The question whether a physician after being in attendance on a patient may be compelled to testify as an expert may be answered in the affirmative if such physician can qualify as a technical expert on the particular ailment or disability involved in a given case. In other words, actual observation should, if anything, lend greater strength and credibility to a medical expert's testimony than a theoretical response to a hypothetical question.

Preparation

Still another important difference between the nonexpert and expert witness lies in the amount of preparation prior to appearance before the tribunal. While the nonexpert witness will ordinarily not be expected to do more than review his case notes and tell what he has observed, and what he knows as a result of such observation, the expert cannot stop at this point. By the very reason of his being an expert he is supposed to know much better than his nonexpert fellow physician the medical literature, the laboratory aspects, and the technical medical side of the particular point in issue. This presupposes preparation of a most careful character. Wherever possible, it will presuppose examination of the patient and a personal knowledge of the history of the case. This is not always possible in the case of adverse parties, or of a deceased, and it is for this reason, among others, that opinion evidence and the hypothetical question are so commonly employed.

The Hypothetical Question

Much has been written, a good deal of it critically, of the hypothetical question which is so commonly employed in the examination of expert witnesses. Such a question has been defined as "one which states and assumes as true certain probative facts appearing in evidence, and asks the opinion of the witness thereon as to some ultimate fact in issue." Hypothetical questions should be so formulated as not to invade the fact-finding province of the jury; they need not be limited to undisputed facts, but should not contain facts which are not before the tribunal. Such questions should cover sufficient ground to justify invoking expert opinion, should be technically as accurate as possible and should never be unfair or misleading.

Hypothetical questions have frequently found disfavor both with courts and the medical profession, but they serve a perfectly legitimate function, namely that of assuming a given medical or other factual situation, thereby filling gaps in the witness' own opportunities for observation and diagnosis in a given instance. Such questions also serve as a check on the facts, and further, afford a basis for prognosis which is frequently all-important in personal injury or industrial cases.

Where it happens that an expert witness has likewise treated the patient he is competent not only to testify on the basis of what he has seen and knows of the specific case, but also to give opinion evidence and to answer hypothetical questions.

Compensation

The question of compensation very properly arises in connection with expert medical witnesses. By very reason of the fact that such witnesses are expert they customarily command higher remuneration than do general practitioners; they commonly travel a longer distance; they are expected to prepare much more fully and comprehensively than nonexperts. Skill, special knowledge, exceptional or even unique experience, all distinguish them from the ordinary medical witness. All of these marks of the expert may properly be weighed in considering what constitutes fair compensation for the testimony of such a person.

Warning cannot be too strongly sounded, however, that while an expert should have compensation which is fair under all the circumstances, he should not be given a monetary interest in the outcome of the litigation, nor should his compensation in any way depend upon the character or emphasis of his testimony. His compensation must always have professional rather than commercial limits. Whenever the facts are otherwise the result in too many cases will tend to be at least an unconscious coloring of such expert's testimony because of his almost proprietary interest in the consequences of what he says. Both legal and medical literature are replete with warnings against luring the expert witness from a professional plane and making him what is for all practical purposes almost a proponent in the litigation. An expert who so acts reflects discredit on himself, on his profession and on the entire practice of permitting the offering of opinion evidence.

Decalogue for Physician Witness

No better guide is available for the almost religious observance of both nonexpert and expert medical witnesses than the following decalogue, brought to the attention of the medical profession by Dr. A. I. Rosenberger, Milwaukee, who in turn has ascribed it to Dr. W. E. Grove, Milwaukee:

1. Examine your case thoroughly and repeatedly so that you know what you are talking about. Know your facts well. They must be incontrovertible. The opinion you form from these facts is your own, but must be arrived at honestly.

2. Testify slowly, clearly, simply, and in language that the layman can understand. Forget your Latin medical terms. Remember that the jury is obligated to determine facts, and it does so intelligently only when it understands you.

3. Stick to the unvarnished truth. If you do not, your statements will strike back at you like a boomerang.

4. Do not become partisan or assume a proprietary interest in the legal proceedings, for if you do, it will diminish your value in the eyes of the court and the jury.

5. Maintain your dignity and do not advise or consult with an attorney in the courtroom, but sit far away from him. The attorney should prepare his case before he goes into court.

6. You are not required to answer by "yes" or "no" an involved question if such answer places you in the position of the man who was asked, "Have you stopped beating your wife?" Your "yes" would be a lie and your "no" a prevarication.

7. If a long, involved, hypothetical question is to be propounded to you, request that it be given to you in writing before you are put on the stand so that you may thoroughly study it and not embarrass your attorney by your answer.

8. Refuse to answer any question which puts you into some other field of medicine than your own. You may always say, "I cannot qualify."

9. Do not allow an attorney of the blustering, bulldozing type to anger you or "get your goat." The purpose of this line of questioning is to throw you off guard.

10. Remember that at times the most valuable words in the English language are, "I do not know."

$210,000 PAID TO WISCONSIN PHYSICIANS

The Provident Life and Accident Insurance Company, underwriters of the Society Group Disability Insurance Program, announced that claim payments to Wisconsin physicians totaled approximately $210,000 for the contract year ending August 15, 1954. During this time, 267 physicians received final payments from the company.

The Disability Program was instituted in August, 1950. Since that time, 11 claims for disability resulting from a sickness reached the maximum of 104 weeks of payment. In addition, the accidental death benefit of $3,000 was paid in four cases.

This insurance is available to members of the Society in the active practice of medicine who are less than 70 years of age. Benefits for insured members are available through age 74. The basic program provides for total disability payments of $75 per week for total disability resulting from an accident or sickness. Partial disability benefits are $37.50 per week. There are also substantial payments for accidental death and dismemberment. A physician will be allowed $10 per day while confined to a hospital and, in addition, up to $100 to cover hospital expenses other than for room and board.

Last year an optional benefit of an additional $25 of weekly disability payments was offered to members in good health between the ages of 34 and 60, provided the member does not carry more than $150 weekly indemnity under plans made available to him by reason of membership in other professional organizations.

One of the great advantages of a group program as opposed to individual insurance is that eligible members may subscribe without submitting the usual health questionnaire, provided that their application is made when they become eligible. New members of the Society who are under age 32 may apply within one year and the members over 32 within 6 months, without consideration of present physicial condition or past medical history. Group insurance also provides a considerable premium advantage.

Physicians who do not purchase this program at the time it is first offered to them may apply at any time, but the company may accept or reject such applications on the basis of a health statement which must be provided at the physician's expense.

The Provident Plan is the only group disability insurance program officially sponsored by the State Medical Society. Similar policies available to the medical profession through other state societies and the national specialist organizations have been examined critically; and so far as it is known, the Wisconsin program continues to offer the most in income protection benefits per dollar of premium charged.

Additional information on this subject is available through the Society offices.

All benefits outlined above are subject to the terms of the policy.

Physician, Patient, and the Professional Secret

THE respect which the physician has, as a matter of course, for his patient's privacy is formalized in one of the principles of medical ethics:

> "Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state." *(Principles of Medical Ethics of American Medical Association, Chapter 2, Section 2.)*

Legal Status of the Professional Secret

The duty, thus imposed by ethics, is enforced by law. A Wisconsin statute, Section 147.20 (1) (d), includes the willful betrayal of a professional secret as a ground for revocation of a physician's license.

Both the ethical principle and the law recognize that the patient's right of privacy is less than absolute and that there are times when the physician's duty is to reveal, rather than to conceal, what he has learned about the patient in the course of professional treatment. The right and correlative duty are not grounded on sentiment; they are based on considerations of reason. Fair play will cause every person to hesitate before publishing what another has told him in confidence. But the physician is not "every person"; nor is the patient just "any other." The physician-patient relationship is a special one, and the rights and duties surrounding professional secrets are special rights and duties that arise from the special quality of that relationship.

Every person's desire to protect secrets is subject to at least one important restraint. When called to testify before a court, he is sworn to tell the "whole truth" as well as "nothing but the truth." The ordinary rule subjects him to punishment for contempt of court (which is to say, contempt for the symbol of the law itself) if he refuses to answer a question properly put to him. And this is as it should be. If courts are to decide issues by applying the law to the facts, the courts must be empowered to demand revelation of the facts. The court's power to insist on revelation can reasonably be curbed only when the reason for concealment is more worthy of respect than the business of the court itself.

Generally speaking, the business before courts is weighty business. Only exceptionally does our law concede greater weight to other matters. The law's high regard for the person's ordinary right to freedom is shown in the constitutional privilege to refuse to testify in a way that might tend to incriminate the witness himself. Its respect for the integrity of the home has put limits on the testimony that might be demanded from spouse against spouse. Its recognition of the social stability that the practice of religion encourages has led it to hold inviolate the seal of the confessional. The value the law places on the well-being of the human body is shown in the privileged status it gives to communications made by a patient to his physician. In Wisconsin, this privilege is set out in Section 325.21 of the Statutes:

> *Wisconsin Statutes*, §325.21. "Communications to doctors. No physician or surgeon shall be permitted to disclose any information he may have acquired in attending any patient in a professional character, necessary to enable him professionally to serve such patient, except only (1) in trials for homicide when the disclosure relates directly to the fact or immediate circumstances of the homicide, (2) in all lunacy inquiries, (3) in actions, civil or criminal, against the physician for malpractice, (4) with the express consent of the patient, or in case of his death or disability, of his personal representative or other person authorized to sue for personal injury or of the beneficiary of an insurance policy on his life, health, or physical condition."

The Patient's Privilege and the Physician's Duty

The foregoing statute appears in the chapter on "Witnesses and Oral Testimony." If it were repealed, it would make no change in the physician's legal as well as ethical duty to keep secret what he has learned from or about his patient in the course of professional treatment. Section 147.20 would continue to put the physician's license in jeopardy if he should violate his duty. Actually, it is Section 147.20 that is the primary concern of the physician. Section 325.21 is rather the concern of the patient himself or of his attorney when the patient becomes or is about to become involved in litigation. The physician, guided by Section 147.20, is well advised never to speak about his patient's affairs (1) unless he has the express consent of the patient himself or of someone identified by competent legal authority as empowered to consent for him, or (2) unless he is commanded to speak by the presiding judge of a court. This advice borrows from Section 325.21 for aid in interpreting Section 147.20, but the advice would be just as sound tomorrow, even if Section 325.21 were repealed today.

Precautions for the Physician

Certain points in the above advice deserve special emphasis. If it is consent that the physician relies on as his authority for revealing a patient's secrets, let the physician be sure that it is *express*. He will more easily determine whether or not it is express if the patient puts it in writing; and if the patient affixes his signature to the writing, the physician will be better able to persuade the State Medical

Grievance Committee or a court that he had spoken with consent, if trouble should later arise. Whenever possible, then, let the physician demand a signed consent and then let him heed any limits with which the writing circumscribes the consent.

If the physician relies on consent given by another on behalf of the patient, let the physician be sure not only that the consent is express, but also that the person giving the consent is able to consent for the patient. In the most common situations, the physician can be sure without seeking further assurance from his attorney. For example, when the patient is still a minor child, a parent, as natural guardian, is capable of giving the consent; but if the parents are dead, let the physician be sure that the guardian who offers a consent for the child has been legally appointed as guardian. If the patient has died, the physician may rely on letters testamentary or letters of administration as sufficient identification for an executor or administrator of the patient's estate who might validly proffer express consent for the revelation of professional secrets. But the physician should not rely, without preliminary investigation, on a consent proffered simply by a member of the family of a deceased or incapacitated patient. Such a person may, or may not, be legally competent to consent.

Some Problems for the Physician's Attorney

The physician's attorney, in determining whether or not a person is competent to waive secrecy for a patient, will note first of all that Section 325.21 of the Wisconsin Statutes permits a substitute for the patient's personal consent only if the patient himself is dead or disabled. The disability meant is, of course, not such disability as the physician diagnoses, but *legal* disability. It is for this reason that a parent can consent for a perfectly healthy child. In the case of, for example, the mentally incompetent adult patient, the investigation should show that the incompetence has been legally determined and declared before substituted consent should be relied on. The physician then can rely on consent from the patient's legal guardian.

The next thing that the physician's attorney will note in Section 325.21 is that, given the prerequisite death or disability, then there are only three categories of persons who qualify to give substituted consent. They are: (1) the patient's personal representative; (2) any other person authorized to sue for the patient's personal injury; and (3) any beneficiary of an insurance policy on the life, health, or physical condition of the patient.

The third of these categories is self-explanatory, but the physician's attorney would want to check whether the insurance policy was in force and to examine the policy and its endorsements for a sure identification of the beneficiary. The first two of the categories might become somewhat more involved. "Personal representative" was defined by statute in Wisconsin for the first time by the 1953 legislature. It is defined for a limited context (as used in Chapters 310 through 324) only, and whether the meaning there given would carry over, in a troublesome case, into Section 325.21 remains for the courts to decide. The cautious attorney would, for the present, take the narrow view. As for the second category, the physician's attorney would again be cautious. He would inquire into the relationship between the patient and the person offering a substituted consent and would then check both the common law and the statutes to determine whether the substitute had authority to sue for the patient's personal injury. He would also want to know, for example, whether the injury had been suffered in an industrial accident. These are clearly matters for the physician's attorney, not for the physician himself, to study.

Legal Scope of the Professional Secret

Scope of the Patient's Privilege

The privilege statute, Section 325.21, though not so important to the physician as Section 147.20 (1), which puts a legal sanction on his ethical duty to guard his patient's secrets, is an aid both to the physician and his attorney in better understanding the physician's duty. The consent clause of Section 325.21 emphasizes the fact that to be secretive is the patient's privilege, not the physician's. Other clauses of the section still further clarify the law's view of the professional secret.

First of all, Section 325.21 suggests that not everything related by patient to physician receives the protection of the law, but only what is "necessary to enable him professionally to serve such patient." Obviously, many a remark volunteered by a garrulous patient would be outside the scope of the privilege, but this does not mean that all the information, to be privileged, must turn out to be actually useful in diagnosis and treatment. The physician, in order to evoke the facts that he needs, may judge it necessary to encourage free and easy talk. Disclosures made under such circumstances should be privileged, for, in the judgment of the physician (who is the best judge of such matters), they are necessary to enable the physician to serve his patient professionally. They would probably qualify as professional secrets.

Secondly, Section 325.21 indicates what reasons are more important than the reason for which the law undertakes to protect the secret revealed by patient to physician. It has already been suggested that the reason for the patient's privilege is the law's regard for the integrity of the human body. The law wants the sick to take the steps necessary for the restoration of health, and to have the will to keep themselves well. The law recognizes that often, as a practical matter, the physician cannot care for the patient intelligently unless he is informed of many a fact that would do the patient no credit in the community—or, at least, that a sensitive patient would not want to have published. To encourage the patient, for his health's sake, to approach his physician with confidence, the law lets the patient know

that, except for reasons more compelling than the patient's health, his secrets will be safe. Only to prevent miscarriage of justice in homicide trials, to permit the facts to be disclosed in lunacy inquiries, or to protect the physician himself against charges for malpractice, will the law permit its own courts to draw the patient's secrets from his physician without the patient's consent. The physician will be prudent to assume that the law will be no more generous to him than to its own courts if he should, outside of court, consider revealing a professional secret.

In the third place, Section 325.21, in its terms, restricts only the physician from testifying. And Section 325.21, since it creates an exception to the general rule that courts are entitled to the whole truth from witnesses, is construed narrowly by the courts. That is to say, the terms of the statute are not expanded to include nurses, hospital technicians, internes, unlicensed internes, and the like who regularly give assistance to the physician. The patient may not claim his privilege with respect to any of his secrets they have acquired. The physician, therefore, does a favor to his patient when he permits his assistants to obtain only such private information about his patient as they must know in order to render their assistance efficiently.

Fourthly, Section 325.21 has no application except where there was a genuine physician-patient relationship. Information obtained by a physician in the case of an autopsy is not privileged. Neither is information obtained by a physician in the course of an examination made for purposes other than the diagnosis and treatment of the examinee. If a physician who is also a health officer acquires information while making an examination in his capacity of health officer, there is no privilege. The same principle applies where a physician examines an applicant for life insurance. However, the fact that this principle governs in determining whether information is exempt from the rule that a witness in court must tell the "whole truth" does not necessarily mean that the physician is exempt from a legal duty under Section 147.20 (1) to refrain from willful disclosures.

Scope of the Physician's Duty

But Section 325.21, the privilege statute, does not tell the whole story about the physician's legal duty to protect professional secrets under Section 147.20 (1). Actually, the physician will often have the duty to reveal information under circumstances not hinted at under Section 325.21. Whatever the circumstance, however, the prudent physician will ask for a written signed consent before making any revelation.

Among the situations, in addition to those suggested by the privilege statute, in which the physician properly discloses matters otherwise to be kept secret are: (1) those in which the patient has made a claim under the Workmen's Compensation Act; (2) those in which the physician has discovered the presence of diseases which he is by law required to report to public authorities; and (3) those in which overriding ethical considerations make disclosure necessary.

Under the Workmen's Compensation Act, an employee making a claim for an occupational disease or for an injury suffered in connection with his employment obviously is in no position to require the physician who treated him to withhold his findings from the Industrial Commission. In personal injury cases in general this same principle is often applied. Under Section 269.52 (2) of the Wisconsin Statutes, a court may require a party claiming damages to undergo a physical examination by a court-designated physician, and to submit his x-ray photographs and hospital records to the defending party for study, or forego his right to use those x-rays or records on his own behalf at trial. In the Industrial Commission's application of this principle, though the privilege as such is inoperative, some deference is paid to it. The Commission has said:

> "It is a practical necessity that the physician attending the injured workman furnish information to the Commission upon which to base compensation. Physicians will not be required, however, to disclose confidential communications commuted to them for the purpose of treatment and which are unnecessary to a proper disposition of the claim. The Commission regards the physician who treats the injured workman at the request of the employer, to all intents and purposes, the physician of the injured man. His testimony before the Commission should be absolutely fair and unbiased."

It is equally a matter of practical necessity, where communicable disease puts the public health in peril, that such disease, when detected by a physician in the course of treating a patient, be reported to the proper authorities. Included in this category are, of course, venereal diseases. The law also requires physicians to report cases of occupational disease; congenital deformities in newly born infants; and cancer, carcinoma, sarcoma, or other malignant growths.

Practical necessity will often also move a physician to disclose information on his own initiative to persons not specifically authorized by statute to receive it. Sometimes, says Section 2 of Chapter 2 of the Principles of Medical Ethics of the American Medical Association, "a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances." Take, for example, the situation in which the psychiatrist, prior to a judicial determination of the patient's insanity, must, according to the dictates of good common sense, warn the patient's family, or even

his associates or neighbors, of possible physical danger to them.

Good sense and ethics similarly will solve the problem presented occasionally upon premarital examination. The physician may find that while the applicant is free from venereal disease, he does have some physicial or mental disability or abnormality which would render him unfit for marriage or would make impossible the consummation of a satisfactory marriage relationship. The question then arises as to the liability of the physician upon disclosure of his findings to the other prospective spouse.

This problem is discussed in an article appearing in *The Ohio State Medical Journal* for November 1941. Believing that the conclusions there drawn are of equal merit in Wisconsin, we reprint here the conclusions both as to (1) the liability of the physician to the examinee, and (2) the liability of the physician to the state.

> "A physician, disclosing to the other prospective marital partner disabilities or ailments of an examinee that would endanger the other party to the prospective marriage or that it would make it impossible for the parties to enjoy a happy or satisfactory marriage relationship is subject to no liability to the examinee, either in libel or slander or for disclosing a professional secret within the limitations noted; that is, if he acts in good faith and without malice, and makes no further disclosures than is reasonably necessary under the circumstances. Obviously, the problem is simplified if the same physician examines both parties with the definite understanding that findings and observations, if at all material to the prospective relationship, shall be made known to the other party; or if the physician acting with respect to one party only enters into a similar understanding."
>
> "The disclosures under the circumstances here assumed would not constitute the 'wilful betrayal of a professional secret' and would not be the basis for the revocation of the physician's license."

What Is a Wilful Betrayal?

In confidently following the dictates of his professional judgment and his personal sense of ethics when problems on which no definite law has yet been formulated present themselves, the physician may be reasonably sure that he will not run afoul of the sanction with which Section 147.20 (1) (d) protects the patient's privacy. Before the physician's license may be revoked for violation of his legal duty in this matter, he must be found guilty of "willfully betraying a professional secret." "Willfully betraying" has not yet been defined by the Wisconsin Supreme Court, but it seems possible that a court might require a showing of some malice on the part of a physician to support such a charge against him. The words "willful" and "betraying" are strong language, and in the context of ordinary speech they represent a most serious accusation of misconduct. At the very least, it seems likely that a court would find no such flagrant violation unless the physician had fallen clearly—perhaps recklessly—short of the standards of professional judgment in making his disclosures.

UNIVERSITY OF WISCONSIN INSTITUTES RESEARCH UNIT FOR STUDY OF AMYOTROPHIC LATERAL SCLEROSIS

Physicians Urged to Refer Patients for Evaluation

A research unit for the study of amyotrophic lateral sclerosis and allied disorders has been established at the University of Wisconsin Medical School. It is supported and financed by the Detling Foundation and is currently under the leadership of Dr. Peter L. Eichman. Participating in the study are: Dr. P. Settlage and graduate student R. P. Bunge in the Department of Anatomy, Dr. G. ZuRhein of the Department of Pathology, and Drs. Hans H. Reese and Henry A. Peters of the Department of Neuropsychiatry.

The primary purpose of the study is an advance in the knowledge of this clinical disorder, its possible etiologic mechanisms, and the use of the various therapeutic measures. Arrangements have been made for the evaluation of patients suspected of having this disease. Patients may be seen as outpatients for immediate evaluation, though admission to the hospital for detailed clinical studies is carried out in the usual manner for hospitalization to the University Hospitals at Madison 6, Wisconsin.

If you have patients with the spinal form with its muscular atrophy, fasciculations, and spastic weakness of the legs, without sensory disturbances, or the bulbar type with dysphagia, nasal speech, fasciculations of the tongue, and the like, we should be most interested in evaluating the syndrome as a part of our program of study for you. Full clinical reports will be sent to you following our examinations. With your cooperation we would also like to offer several types of treatment.

Narcotic Laws and the Practitioner

NARCOTIC traffic in this country is controlled and regulated by both federal and state law. The Harrison Narcotic Act is the basic federal enactment in the field, and it is upon that law that the Narcotic Bureau regulations and other applicable federal statutes are based. It was drafted as a revenue measure, for only through the taxing power can the federal government control or regulate traffic in drugs within the states themselves, but it was primarily intended, as Justice Holmes pointed out in *United States v. Jin Fuey Moy,* (1916) 241 U. S. 394, to control and regulate the sale and use of narcotics.

The federal act, however, because of constitutional limitations on the scope of its operations, was not sufficient. State legislation was needed to supplement the federal act and, in 1935, the Wisconsin Legislature adopted the "Uniform Narcotic Drugs Act." It facilitates the regulation, control, and enforcement over narcotic sale and use in conformity with the aims and purposes of the federal act. In drafting the state law, effort was made to avoid any duplicate effort, either on the part of the enforcement officers or the persons subjected to the act. The state law makes specific reference to the federal act and provides that a compliance with the federal law shall constitute a compliance with corresponding sections of the state law.

Use of Narcotics and the Practitioner

The purpose of this article is to summarize those provisions of both state and federal law which have particular application to the medical profession.

First of all, the practitioner can dispense or prescribe narcotics only in connection with patients upon whom he is in attendance in the regular course of his professional practice. Except for the possession and use of opium pipes, or marijuana, hemp, or loco weed in a form suitable for smoking or beverage purposes, neither the state nor federal act places any limitation upon the physician as to the quantity of narcotic that may be dispensed or prescribed.

The narcotic drugs regulated include opium; coca leaves; cannabis; isonipecaine; and any compound, salt, derivative, or preparation of them. Exempt are medicinal preparations containing not more than one grain of codeine or one-sixth grain of dihydrocodeinone or any of their salts per ounce of the medicinal preparation. Such a preparation must also have medical value other than that possessed by the narcotic alone. All other preparations are in the prescription class.

In consideration of the narcotic laws' application and the very severe penalties incurred for even technical violations, it would be well for the practitioner to consider the matter from the following three functions which he may perform: administering narcotics, dispensing narcotics, and prescribing narcotics.

1. **Narcotics Administered by Practitioner**—It is in this function that the practitioner is given some latitude in the use of narcotics. The law requires the physician to maintain a record of any narcotic drug administered, but exempts

> Narcotic drugs administered, dispensed or professionally used in the treatment of any one patient, where the amount administered, dispensed or professionally used for that purpose does not exceed in any forty-eight consecutive hours, (a) four grains of opium, or (b) one-half of a grain of morphine or of any of its salts, or (c) two grains of codeine, or of any of its salts, or (d) one-fourth of a grain of heroin or of any of its salts, or (3) a quantity of any other narcotic drug or any combination of narcotic drugs that does not exceed in pharmacologic potency any one of the drugs named above in the quantity stated.

2. **Narcotics Dispensed by a Practitioner**—Under both state and federal law, the practitioner is required to keep a record of all narcotic drugs dispensed by him, such record showing the amount, date dispensed, and name and address of the patient; this record must be kept for two years. One record will suffice for both federal and state requirements. When the practitioner's office is accessible to the patient, the dispensing of narcotics should be avoided as much as possible; certainly no more should be placed in the hands of patients than is necessary to provide until the next visit.

Attention is called to a special rule applicable to physicians dispensing exempt narcotic preparations. The rule is expressed both in the federal act and in the treasury regulations and provides that a dispensing physician, among others, must keep a record of all sales, exchanges, gifts, or other disposition of such exempt preparations. The record of disposition must be made at time of delivery and must show the name and address of the patient, the name and quantity of the preparation, and date of delivery.

3. **Narcotics Prescribed by a Practitioner**—The laws do not compel the practitioner to keep records of the prescriptions issued, but the physician's case records should be complete and in detail. His prescription to the patient must be written and signed in ink or indelible pencil and must give the name, office address, and narcotic registry of the physician; the name and address of the patient; the kind and quantity of narcotic; directions for use; and the date of issuance.

A pharmacist may fill a narcotic prescription only upon receipt of a written prescription. Attention has been called by federal narcotic authorities to practice on the part of some physicians to telephone narcotic prescriptions with the intention of later mailing or delivering them to a pharmacist for filing. Such a practice is contrary both to federal and state law, although there is nothing to prevent the physician from notifying his pharmacist by telephone that such a prescription is on its way. The pharmacist must have the prescription in his possession, however, before delivery can be made.

The Physician and the Drug Addict

No doubt the physician's most vexing problem in the field of narcotics is presented by the drug addict. By every conceivable means—from threat of great violence to the most subtle fraud—he preys upon the practicing physician in a desperate effort to procure the narcotic which will satisfy his craving. There may never be a complete elimination of this problem so far as the physician is concerned; but, at least, his responsibilities under the law are clear.

A physician may dispense, administer, or prescribe narcotics "to a patient" provided that it is "in the course of his professional practice only." The courts have universally held that the use of drugs for the sole purpose of satisfying the craving of an addict is in violation of the law and subjects the physician to the severe penalties provided.

The physician must never give narcotics to a "transient addict" merely to satisfy his narcotic requirements; but if the physician determines *after* a physical examination that the addict is in need of medical treatment and that as a part of such treatment he should have narcotics in an amount which is reasonable for the treatment of the particular disease, the dispensing or administering of that amount is permissible. The practitioner should bear in mind that the best professional opinion seems to recognize the fact that an attempt to cure an addict outside the walls of a hospital or other institution is almost certainly doomed to failure, and that an attempt to cure under such circumstances may furnish grounds for suspicion of violation.

What can be done for the addict in Wisconsin? Certainly he can be encouraged to seek treatment on a voluntary basis in federal, state, or private institutions. Failing that, he may be committed against his will to the county hospital or to the Winnebago or Mendota state hospitals. Section 51.09, Wisconsin Statutes, provides the procedure. It requires an application to any judge by three adult persons resident of the same county as the addict, which application asserts addiction to narcotics or barbiturates. If the judge determines at a hearing that the person is a drug addict and requires confinement or treatment, or that commitment is necessary for the protection of himself, his relatives, or the public, he can be committed for so long as is necessary to enable the addict to take care of himself. The same statute provides for commitment on the identical basis but without a hearing if the addict voluntarily applies for treatment to the judge.

Patient "Narcotic Permits"

Neither the state nor federal laws confer on *any* narcotic or other governmental enforcing agent *any* authority to grant any kind of permit to any individual purporting to entitle him to have narcotics dispensed or prescribed for his personal use. The government, both state and federal, leaves this entirely up to the professional judgment and good faith of the medical profession. No such purported "permit" presented by a patient has any legal validity whatever and, therefore, affords the physician no protection.

Marijuana

It should be noted that the Harrison Narcotic Act does not regulate the production, manufacture, sale, or use of marijuana. Instead, this is made the subject of separate federal regulatory legislation which is in terms almost identical with that on narcotics. A physician desiring to administer, dispense, prescribe, or give away marijuana must, in order to comply with the federal act, first be registered for such purpose separately from his narcotics registration and must keep records similar to but independent of those showing disposition made of narcotics. The Wisconsin act includes cannabis, of which marijuana is a variety, in the definition of narcotic drugs, thereby making the act uniformly applicable to coca leaves, opium, and marijuana.

The term "cannabis" under the statute includes all parts of the plant Cannabis sativa L., whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of such plant, its seeds, or resin. There are exempted from the definition only the matured stalks of the plant, the devitalized seed and seed products.

Important Federal Requirements and Date Lines

1. A physician desirous of using narcotics or marijuana in the course of his professional practice, who is registering for the first time, may do so at any time of the year. He should first request a narcotics application form from the office of the Director of Internal Revenue, Federal Building, Milwaukee. This should be carefully filled out, witnessed or notarized, and returned to the collector, together with a special annual tax of $1.

2. Physicians who have registered before under the narcotics law will receive reregistration Form 678 from the Director of Internal Revenue in May of each year. This should be carefully prepared and returned along with the annual tax of $1 *on or before July 1 of each year.* A physician who does not receive a reregistration form on or before July 1 is **under duty to request one from the collector.**

3. There must accompany the registration application and annual tax a sworn inventory on Form 713 showing narcotic drugs on hand in the physician's office. This, like the reregistration and tax, must be filed on or before July 1 of each year.

4. A physician may *not* order narcotics on his own prescription blank, but must use the official duplicate order book prescribed by the Director of Internal Revenue, which may be purchased from the Director's office, Federal Building, Milwaukee, for 10 cents. The order book may be requested on Form 679.

5. Unless a physician has registered, paid his tax, and filed an inventory, on or before July 1 of each year, it is a violation of law for him to administer, dispense, prescribe, give away or transport narcotics or marijuana until he has first complied with the law in all above respects. In the case of narcotics it is a violation of law for the physician even to be in possession of such drugs under these circumstances.

6. Fines are imposed on a physician who either negligently or wilfully fails to keep or display in a prominent place in his office the stamps denoting payment of the special annual tax on the use of narcotics or marijuana for professional purposes.

7. A physician who maintains two or more offices in different locations must register each office separately and pay the special annual tax of $1 for each.

8. The physician should report stolen narcotics at once to the narcotics district supervisor who at the present time is Albert E. Aman, 817 New Post Office Building, Chicago 7, Illinois. Accompanying the report should be an affidavit which sets out the circumstances of the theft so far as they are known to the physician, the quantity taken, and the further fact that prior to making the affidavit local police authorities have been notified of such theft. A copy of such affidavit is to be retained by the physician and filed with his other narcotic records so as to be available at any time for inspection.

9. The following should be reported promptly to the Director of Internal Revenue, Federal Building, Milwaukee:

(a) Removal of office. This is merely a matter of reregistration and does not require a new permit or payment of an additional tax.

(b) Discontinuance. A registered physician desirous of discontinuing either his practice or the administration, prescription or dispensing of narcotics or marijuana should notify the Director of his intention not later than June 30, the close of the tax year. He will receive special instructions as to disposing of his stock, etc.

(c) Death. The death of a physician should be reported promptly to the Director, and instructions will be received as to the disposition of remaining stock.

10. The physician should remember that if he desires to use marijuana in the course of his professional practice he must register, pay a tax and furnish an inventory on marijuana independently of those same requirements for narcotics, the latter being restricted by statutory definition to opium or coca leaves, or any compound or derivative thereof.

11. No registration is required under the Wisconsin act by physicians desirous of making professional use of coca leaves, opium or cannabis.

12. The commissioner holds that a physician who purchases a stock of narcotics beyond his reasonable needs for the ensuing ninety days is making excessive purchases. The physician who has an excessive narcotic stock on hand runs the risk of theft, ties up his money, and also runs the risk of a special investigation by a narcotics agent.

The Wisconsin office for the Federal Bureau of Narcotics is located in the Federal Building, Madison, and any communications or inquiries should be sent to the narcotics agent at the above address.

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The eighteenth annual meeting of The New Orleans Graduate Medical Assembly will be held March 7 to 10, with headquarters at the Municipal Auditorium.

Eighteen outstanding guest speakers will participate, and their presentations will be of interest to both specialists and general practitioners. The program will include fifty-four informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, medical motion pictures, scientific exhibits, round-table luncheons, and technical exhibits.

The Assembly has planned another interesting postclinical tour to follow the 1955 meeting in New Orleans. On Saturday, March 12, a party composed of doctors and their families will leave New York for Europe via Pan American World Airways' "President Special." The itinerary includes France, Italy, Germany, Denmark, Sweden, and England; and arrangements have been made for medical programs in these countries. The tour ends in England, and the group will return to New York, sailing April 7 from Southampton on the "S. S. Liberte," or by Pan American World Airways.

Details of the New Orleans meeting and the postclinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.

Dispensing of Drugs by Physicians and Their Employees

QUESTIONS regarding the legal implications of dispensing of drugs by physicians or their employees have arisen from time to time. The opinion of the attorney general of the State of Wisconsin, set forth below in its entirety, discusses in clear and simple language the physician's possible legal liabilities, generally, as well as the extent of his and his employee's authority to dispense drugs.

"*Physicians and Surgeons—Pharmacy:* Dispensing of drugs by physician to patient in course of professional treatment is exempt from provisions of ch. 151, the pharmacy law, and no violation of sec. 151.04 (2) or 151.07 (3) Stats., is involved where the particular prescription is delivered to the patient by the office girl who has been directed by the physician to select certain tablets from a designated container and package the same under the general supervision of the physician."

January 29, 1952

Mr. Sylvester H. Dretzka, Secretary
State Board of Pharmacy

"You have asked for our opinion as to the latitude which a physician may grant his office girl in the dispensing of drugs and for purposes of illustration the following factual situation is presented:

> 'The doctor has a stock of drugs on hand. After naming a patient, he orally or in writing instructs his office girl to furnish the patient with certain drugs. The girl selects a container from among several (For example—10 or more varieties of Sulfa tablets), and counts out the number indicated. She then packages and labels the package. The exchange is also completed by her with the patient. This girl, without professional training, prepares the entire transaction which would normally be prepared by a pharmacist as required.'

"We are asked whether this constitutes a violation of secs. 151.04 (2) or 151.07 (3).

"Sec. 151.04 (2) provides:

> '(2) No person shall sell, give away, barter, compound or dispense drugs, medicines or poisons, except paris green, in packages labeled "paris green, poison," nor permit it, in a town, village or city of five hundred or more inhabitants, unless he be a registered pharmacist, nor institute nor conduct a place therefor without a registered pharmacist in charge, except that a registered assistant pharmacist may do so under the personal supervision of a registered pharmacist, and may have charge during the pharmacist's necessary absence, not to exceed ten days. If the inhabitants are less than five hundred, only a registered assistant pharmacist is required.'

"So far as material here an exception to the foregoing provision is contained in sec. 151.04 (3) reading:

> '(3) This shall not interfere with the dispensing of drugs, medicines or other articles by physicians, * * *'

"Sec. 151.07 (3) provides:

> '(3) No person, except a registered pharmacist or a practitioner shall prepare, compound, dispense or prepare for delivery for a patient any dangerous drug.'

"In *State v. Maas*, 246 Wis. 159, 16 N.W. 2d 406, which involved the sale of drugs in a drug store by a clerk who was neither a registered pharmacist nor a registered assistant pharmacist, the court said at p. 165:

> 'The drug business is intimately associated with public health. The legislature has prescribed rules and regulations to protect the public from the mistakes of the untrained. Although the statute may be confusing, and very likely can be made to carry the meaning more clearly by a redrafting, its purpose appears to be the prevention of any but registered pharmacists or assistant registered pharmacists under the personal supervision of registered pharmacists, from selling or compounding drugs.'

"The court in that case had no occasion to consider the statutory exception in favor of physicians quoted above, and of course, this language should be read in the light of the factual situation as presented to the court. Nevertheless the case is significant as enunciating the principle that the drug business is intimately associated with the public health and that the purpose of ch. 151 is to protect the public from the mistakes of the untrained.

"See also *Hoar v. Rasmussen*, 229 Wis. 509, 514, 282 N. W. 652, where the court said:

> 'The circumstances of a pharmacist's or druggist's calling demand the exercise of a high degree of care and skill, such care and skill as an ordinarily prudent person would exercise under those circumstances, the highest degree of care and prudence consistent with the reasonable conduct of the business. The effect of a mistake may be swift and disastrous. There are many cases in which druggists have been held liable for injuries resulting from negligence in filling a prescription or supplying a remedy. * * *' (Citing cases.)

"This same principle of solicitude for the public health in the handling of drugs has been enunciated

many times by the courts. See, for instance, *Marigny v. Dejoie* (La. 1937), 172 So. 808, holding that all persons dealing with poisons, especially druggists, are bound to use the highest degree of care known among practical men to prevent injury from use of poisons.

"The hazard to the public health arising through the sale of drugs by an untrained person is equally great whether there is an absence of personal supervision by a licensed pharmacist or a physician.

"In 3 O.A.G. 555 it was considered that a practicing physician is not authorized to run a drug store without complying with the pharmacy law. In other words the exemption in favor of the physician applies exclusively to the furnishing of drugs prescribed by practicing physicians in the treatment of their own patients and they are not authorized to sell drugs to the general public indiscriminately. It is true that at the time the above opinion was written one exemption read: 'Nothing herein shall interfere with any practicing physician when dispensing his own medicines, or supplying his patient with such articles as may seem to him proper.' However, in 16 O.A.G. 722, after the exemption has been changed to its present form the same view was expressed as in 3 O.A.G. 555 with the observation, 'Since said opinion the wording of the pharmacy law has been somewhat changed on this subject, but for all practical purposes the meaning and the significance is the same.' P. 724.

"It is common knowledge that a physician who furnishes medicines to his own patients does not thereby conduct a 'drug store.' *Medico-Dental Bldg. Co. of Los Angeles v. Horton and Converse* (1942 Dist. Ct. of Appeal, 2nd Dist. Div. 3, Cal.), 124 Pac. 2d 56. Sec. 4031 of the California Code relating to pharmacy reads:

> 'This chapter does not apply to or interfere with anyone, who holds a physician's and surgeon's certificate and who is duly registered as such by the Board of Medical Examiners or the Board of Osteopathic Examiners of this State, with supplying his own patients with such remedies as he may desire if he acts as their physician and is employed by them as such and if he does not keep a pharmacy, open shop or drug store, advertised or otherwise, for the retailing of medicines or poisons.'

"There the exemption is more clearly spelled out than it is in Wisconsin, but there is no reason for believing that the legislative intent is particularly different as has been shown above in the administrative construction given our statute.

"So far as responsibility for the negligent acts of their employees are concerned the pharmacist and the physician stand on pretty much the same footing.

> 'In accordance with the elementary principle that the master who undertakes to perform a service is liable for the negligence of his servant who, in the scope of his employment, is performing the service undertaken, it is well settled that when a person has been injured through the negligence of a druggist's clerk, the druggist is liable.' 17 Am. Jur. 'Drugs and Druggists' Sec. 35.

"See also 28 C.J.S. 'Druggists' p. 517, chap. 9 (c).

"Also it is the established rule that a physician must exercise due care in selecting his assistants, and on the simplest principles of the law, agency, or of master and servant, a physician may be liable for the neglect or fault of his employee or servant. 41 Am. Jur. 'Physicians and Surgeons' Sec. 112.

"Following the theory that the exemption in ch. 151 in favor of the physician was intended to apply exclusively to the furnishing of drugs prescribed by a physician in the treatment of his own patient, or possibly the occasional furnishing of drugs to another physician, it would seem that any carelessness in delegating any part of the dispensing to his subordinate where harm resulted to the public might entail liability on the part of the physician or helper or both. But it nevertheless appears that it was not the purpose of ch. 151 to subject the physician or his helper to the jurisdiction of the board of examiners in pharmacy or to make such individuals criminally liable for the illegal dispensing or sale of drugs incidental to the treatment of a patient.

"However, where the relationship of physician and patient does not exist and a member of the general public applies either to the physician or his helper for the purchase of drugs without a prescription the exemption does not apply, since as above pointed out the exemption was not intended for the purpose of placing the physician in the drug store business but merely to help him to supply drugs to his own patient as an incident to their treatment. We understand, for instance, that certain complaints have been filed with the state medical grievance committee under sec. 147.195 wherein investigators have called at the offices of certain physicians and have been sold dangerous drugs such as phenobarbital by the office girl without any prescription whatsoever. In at least one case the sale was said to have been made by the office girl when the doctor was away on an extended vacation. In instances of that sort it may well be concluded that the physician is virtually operating a drug store without meeting the requirements of sec. 151.02 (9) regulating operation of such stores.

"But where the relationship of physician and patient exists many things may be done by an unlicensed assistant pursuant to direction and supervision of the physician and we will certainly not attempt here to gaze into the crystal ball for the purpose of conjuring up all the hypothetical situations which may arise under such relationship along with the appropriate answers to the problems presented. However, to illustrate the extent of the dele-

gation of important and even dangerous tasks to subordinates mention might be made of the fact that nurses administer anaesthetics, make hypodermic injections and attend to medication of patients pursuant to the physician's directions, and it is immaterial whether the nurse is registered or not except that she may not hold herself out as a registered nurse unless she is registered under ch. 149. *See Nickley v. Eisenberg*, 206 Wis. 265, 239 N.W. 426; 9 O.A.G. 87; 30 O.A.G. 245.

"Moreover there is authority to the effect that where a hospital nurse neglected to read the label on a bottle and inadvertently supplied formalin instead of novocaine requested by the surgeon, the surgeon was not liable unless it could be shown that by exercising ordinary care he could or should have been able to prevent injurious effects. *Hallinan v. Prindle*, 17 Cal. App. 2d 656, 62 Pac. 2d 1075. In this case the surgeon was permitted to introduce evidence of the custom of surgeons to accept from the attending nurse instruments, medicine and drugs without personal examination thereof. It should be stated, however, that there was nothing in the evidence to show that the nurse in this case was the servant, employee or even the agent of the doctor, she being the employee of the hospital.

"In view of the foregoing it is concluded that where a doctor has a stock of drugs on hand, and in the course of treating a patient he instructs his office girl to furnish the patient with certain named tablets which she proceeds to obtain from the container and measure out for the patient, delivering the same to the patient, there is no violation of sec. 151.04 (2) or sec. 151.07 (3) although the doctor may be liable for his own negligence or the negligence of his employee in such case. In any event the physician may not, except by complying with sec. 151.02 (9) either directly or indirectly through his employee engage in what amounts to a drug store business by the dispensing and sale of drugs to the general public where the relationship of physician and patient does not exist between him and the purchaser."

VERNON W. THOMSON
Attorney General

SALE OF CONTRACEPTIVES AND ABORTIFACIENTS

The sale of contraceptives and abortifacients or articles appropriate to that use and sold with the intention that they be so used, is prohibited by section 351.235 of the Wisconsin Statutes to all persons other than a physician or pharmacist duly licensed in this state. In no event, may such article, drug or preparation be sold to any unmarried person.

Prohibited also is the advertising or displaying of such articles for sale, or the manufacture, purchase or possession of a machine or device appropriate for vending contraceptives or abortifacients.

Violation of the provisions of this statute subjects the violator to a fine of not less than one hundred dollars ($100.00), or imprisonment in a county jail for not to exceed six months.

PHYSICIANS' EXEMPTION FROM JURY DUTY

Section 255.02 (2) Wis. Stats., 1953, provides exemption of all practicing physicians, surgeons and dentists from serving as jurors. This exemption from jury duty is not a disqualification, however, to act as a juror but is a mere personal privilege which the juror may claim or waive.

Physicians desiring to take advantage of their exemption should appear in court when called to act as jurymen, and should state the cause of their exemption to the presiding judge.

Signing of Death Certificate If No Attending Physician

QUOTED below is an opinion of the attorney general of the State of Wisconsin which clarifies the position of the physician, coroner, and local registrar regarding death certificates in the case where no physician was in attendance. In effect it states that the person desiring to dispose of a body must employ a physician to investigate the cause of death so as to enable the physician to prepare a death certificate.

"*Vital Statistics—Death Certificate:* If there has been no inquest and the physician called for the purpose refuses to sign death certificate (for lack of sufficient information), person desiring to dispose of body has responsibility of procuring a proper death certificate in order to obtain a burial permit under sec. 69.44 (1), Stats., and cost of investigating cause of death is necessary part of burial expense. 29 O.A.G. 470 followed.

"Coroner is not authorized to sign death certificate under sec. 69.41, Stats., unless there has been an inquest. But if there has been an autopsy under sec. 366.121, the autopsy surgeon may sign the death certificate.

"Local registrar may not sign death certificate under sec. 69.40, Stats., merely because physician refuses to do so for lack of sufficient information. He may do so only if no physician can be obtained early enough."

December 7, 1951

Dr. Carl N. Neupert
State Health Officer
State Board of Health

"You have requested an opinion with reference to the preparation of death certificates in cases where no physician was in attendance prior to death and a physician called for the purpose refuses to make a death certificate. You ask three specific questions:

> '1. Who should be held responsible for filling out and signing the death certificate in cases where the physician refuses to sign and where the coroner has not held an inquest?'
>
> '2. Is the coroner authorized to sign a death certificate without having held an inquest?'
>
> '3. Is the local registrar authorized to sign a death certificate when a physician refuses to do so or where a coroner is not authorized to sign the death certificate?'

"The answer to your first question is that the person desiring to dispose of the body by burial or cremation is obliged to obtain a proper death certificate in order to obtain a burial permit under sec. 69.44 (1), Stats., which provides as follows:

> 'The body of any person whose death occurs in this state shall not be interred, deposited in a vault or tomb, cremated, or otherwise disposed of, until a permit for burial or removal is issued, and no burial or removal permit shall be issued until a complete and satisfactory certificate of the death has been filed as herein provided.'

"If a physician's services can be obtained the local registrar is without authority to sign the death certificate. The applicable statutes are secs. 69.39 and 69.40 which provide as follows:

> '69.39 In case of death without the attendance of a physician, or if the certificate of the attending physician cannot be obtained early enough for the purpose, any physician employed for the purpose shall upon the request of the local registrar or his deputy, make such certificate as is required of the attending physician.'
>
> '69.40 When a physician cannot be obtained early enough and *only in such case*, the local registrar is authorized to insert the facts relative to the cause of death, from the statements of relatives or other competent persons, and the permit for burial shall be issued upon such information.'

"As pointed out in the opinion in 29 O.A.G. 470, the local registrar has no authority to employ a physician to investigate the cause of death and the law contemplates that the person desiring to procure the disposition of the body must retain a physician to investigate the cause of death, performing an autopsy if necessary, and pay the physician's fee for that service. Such fee is a necessary part of the burial expense.

"The answer to your second question is that the coroner is not authorized to sign the death certificate unless an inquest has been held. Sec. 69.41, Stats., is the applicable statute and provides as follows:

> 'Any coroner *who holds an inquest* on the body of any deceased person required for a burial permit, shall state in his certificate the nature of the disease, or the manner of death, and if from external causes or violence whether "probably" accidental, suicidal or homicidal, as determined by the inquest; and shall furnish such information as may be required by the state registrar to classify the death.'

"The cases in which a coroner is authorized to hold an inquest are limited by sec. 366.01, Stats. However, even in such cases there may be situations where no inquest is held but nevertheless an autopsy may have been conducted as authorized by sec. 366.121, Stats. In that case the autopsy surgeon could properly make the death certificate, but the coroner could not since his statutory authority is limited to cases where an inquest has been held.

"The answer to your third question is that under sec. 69.40 the only case in which the local registrar

is authorized to sign the death certificate is "when a physician cannot be obtained early enough." Clearly the case is excluded when a physician can be obtained early enough but refuses to make a death certificate because of lack of information. In that case the person desiring to dispose of the body must arrange for the physician to make the necessary investigation of the cause of death and pay him for such investigation, as set forth in the answer to your first question."

VERNON W. THOMSON
Attorney General

Physicians and Child Placement

THE Attorney General, in an opinion to the Wisconsin Department of Public Welfare, concluded that a physician who assists in, or arranges for, the placement of a child by its parent or guardian in the home of a stranger, violates the Wisconsin Statutes. Illustrative cases are set forth and considered in the Opinion, and indicate the extent to which a physician may properly act in this field. The Attorney General's opinion may be found at 37 O.A.G. 403.

Illustrative Cases

"A. The physician who confined Miss A, an unmarried mother, learned that she had expressed a wish to place her child for adoption. He therefore informed Mr. and Mrs. Y, who were patients of his, that he knew of a child that would be available for adoption. He gave the name of the adoptive parents to the mother. They made arrangements to transfer the child to them upon discharge from the hospital. The adoptive parents sent a relative to meet the mother outside the hospital and the relative transported the child alone to the prospective adoptive home.

"B. The physician who confined Miss B, an unmarried mother, learned that she had expressed a desire to place her child for adoption. The physician told the mother that he knew a desirable adoptive home. He communicated with the proposed adoptive family, telling them about the child and suggesting that they employ an attorney. Subsequently the attorney visited the mother and obtained the mother's consent. Upon discharge from the hospital the mother and child were met by the adoptive parents who took the child to their home.

"C. A nurse employed on the staff of the hospital where Miss C was confined, learned that Miss C wanted to make an adoptive placement of her child. The nurse talked to Miss C and informed her that she knew a family who would be interested in adopting her child. She also informed the family about the child and suggested that they come to the hospital to see the baby and to talk with the mother.

"D. Miss D informed her physician that she wished to place her child for adoption. The physician informed her that he knew families who wished to adopt and offered to take the baby and place it in an adoptive home. Miss D consented to this and the physician took the baby to the adoptive home.

"E. Miss E informed her physician that she wished to place her child for adoption. The physician told Miss E that he knew of a good home for the child. Miss E stated that because of her confidence in the physician she would place the child with anyone he recommended. The physician then informed the prospective adoptive parents and suggested that they employ an attorney. They conferred with an attorney, informing him that they had received information from the physician about a child that was available for adoption. The attorney conferred with the mother and arranged through the physician's office to personally take the baby upon the mother's discharge from the hospital. Thereafter, the attorney personally took the baby from the mother and delivered it to the adoptive parents. The attorney justified his actions on the grounds that he deemed it a desirable service to his client to prevent the mother from learning the names of his clients and to prevent the clients from learning the name of the mother. It was the position of the attorney that the mother had made the placement and that he had nothing to do with the actual placement as distinguished from the adoptive proceedings. You inquire whether the attorney violates section 48.37 (1) in that he "assists" in the placement.

"In case A it is our opinion that on the narrow fact situation presented no successful prosecution could be maintained. While it could be argued that one who gives information gratuitously to the parties performs a material act of 'assistance,' it is our view that unless more could be shown it would be impossible to obtain a conviction. If the physician, in addition to informing the prospective adoptive parents of the existence of the child, actively promoted the placement, there would be a

clear violation. But just passing on the information is insufficient in our judgment to warrant a prosecution. The doctor could always say that nothing he did prevented the parties from using proper channels in obtaining the placement. Nor was the act of the relatives in taking possession of the child for the adoptive parents, after the arrangements had been made, sufficient in our judgment to warrant prosecution.

"In case B it is also our view that the physician should not be prosecuted for merely giving the information, particularly since he suggested employment of an attorney. The attorney, according to the facts stated, merely performed a legal service in obtaining the mother's consent and did not 'assist' in or 'arrange' for the placement in the sense meant by the statute.

"It should be repeated, however, that in both cases A and B if additional facts were shown there might well be grounds for prosecution.

"In case C it does not appear that any placement was made, but the nurse informed the mother that she knew of a family who would be interested in adopting the child, and also told the family about the child and suggested that they come to the hospital. Her conduct was not such as to violate section 48.45 (1) because it does not go so far as to constitute a representation that she was *able to dispose of* the child.

"Case D is a clear violation of section 48.37 (1) since the physician did everything necessary to the placing of the child.

"In case E the physician knew that his recommendation would be followed because of the mother's confidence in him. It seems that he did more here than in either case A or case B. It would appear that he *recommended* the prospective foster home. If so he 'assisted' the mother in placing the child by making such recommendation and by putting the parties in touch with each other, notwithstanding his suggestion that an attorney be employed. The attorney also clearly 'assisted' in and 'arranged' the placement. His attempted justification is not valid, since he did more than perform a legal service. His theory would result in exempting attorneys altogether from the application of sec. 48.37 (1). Such exemption was not put in the statute by the legislature and cannot be read into it by implication."

The Attorney General, in the same opinion, discusses the reasons why the state itself, or through its licensed private agencies, has undertaken to perform the function of child placement.

"Experience has shown that so-called 'irregular' placements do immeasurable harm in many respects. They have come to be known popularly as constituting a 'black market' in babies. Even the most well-intentioned persons usually lack the necessary training and are unable or unwilling to make the necessary investigation to determine whether a particular placement is in the best interests of the child. Sometimes, not always, pecuniary matters are permitted to outweigh considerations of the child's welfare, as when the prospective foster parents agree to pay the lying-in expenses. But even in cases where that element is lacking, a great deal of mischief may result. The prospective foster parents may find later that the child has physical or mental defects or conversely the foster home may not be suited for the child. It may happen, too, that proper legal steps to terminate the rights of the natural parent or parents or to obtain their consent to an adoption have not been taken and later on the natural parent or parents cannot be located, or even in some cases identified."

Statutes on Child Placement

"**48.37 Licenses; Records; Reports.** (1) No person other than the parent or legal guardian, and no firm, association or corporation, and no private institution shall place, assist, or arrange for the placement of any child in the control and care of any person, with or without contract or agreement, or place such child for adoption, other than a licensed Child Welfare Agency.

"**48.40 Violations.** (1) Whenever the State Department of Public Welfare shall be advised or shall have reason to believe that any person, firm, corporation, association or private institution, is conducting or acting as a Child Welfare Agency in this state without being licensed as in this chapter provided, or is in any way, directly or indirectly, offering to place any child or holding himself or itself out as being able to place or dispose of children in any manner, it shall make an investigation to ascertain the facts. If it finds that such person, firm, corporation, association or private institution is so acting without a license, it either may issue a license upon application therefor, or may cause a prosecution to be instituted under the provisions of Section 48.41.

"**48.41 Penalties.** (1) Any person who shall act as a Child Welfare Agency without a license as provided in this chapter or who shall violate any of the provisions of the Statutes relating to the organization, conduct and operations of Child Welfare agencies, or who in any way, directly or indirectly, offers to place or dispose of any child or hold himself out as being able to place or dispose of children in any manner whatsoever, shall upon conviction thereof be punished by a fine of not less than ten nor more than five hundred dollars or by imprisonment in the County Jail for not more than one year, and said term of imprisonment in case of an association or a corporation may be imposed upon its officers who participated in said violation."

If questions arise regarding particular cases, it is suggested that the physician contact the Division of Child Welfare at 315 South Carroll Street, Madison, Wisconsin.

Legal Aspects of Abortions and Miscarriages

THE two sections of the Wisconsin statutes which deal with the offenses of causing an abortion under illegal circumstances, or of causing a miscarriage were amended by the 1947 legislature so as to impose more stringent penalties for violations. Both offenses are now felonies, and because of their importance the amended statutes are quoted in full:

Abortion Statutes

"340.095 Any person who shall administer to any woman pregnant with a child any medicine, drug or substance whatever, or shall use or employ any instrument or other means with intent thereby to destroy such child, *unless the same shall have been necessary to preserve the life of such mother or shall have been advised by 2 physicians to be necessary for such purpose*, shall, in case the death of such child or of such mother be thereby produced, be deemed guilty of murder in the third degree. *In case the death of the mother is thereby produced it is unnecessary to prove that the fetus was alive when the act so causing her death was committed.*" (Emphasis added.)

Miscarriage Statutes

"351.22 Any person who shall administer to any pregnant woman, or prescribe for such woman, or advise or procure any such woman to take any medicine, drug or substance or thing whatever, or shall use or employ any instrument or other means whatever, or advise or procure the same to be used, with intent thereby to procure the miscarriage of any such woman shall be fined not less than $1,000 nor more than $5,000 or imprisoned in the state prison not less than one year nor more than 3 years, or both."

It should be carefully noted that the latter section relating to miscarriages does not contain an express exception to protect the physician in necessitous cases as is the case in the abortion statute. Thus there appears to be no statutory sanction for a necessitous miscarriage, regardless of circumstances.

Court Ruling

The Wisconsin Supreme Court attempted to distinguish a miscarriage from an abortion in the case of *Foster v. State*, 182 Wis. 298, holding it evident that the legislature intended to define different offenses in the two sections. The court held that the *abortion statute* required the existence of a *living child* and the causing of its death, or that of the mother, before the offense of abortion is committed. If pregnancy has not advanced sufficiently so that there is a living child, by which is ordinarily meant a fetus at least three months old, then destruction of the fetus constitutes a *criminal miscarriage* only.

Necessitous Operations

The abortion statute above quoted exempts two types of necessitous abortions, the first of which "shall have been necessary to preserve the life of such mother," and the second of which "shall have been advised by 2 physicians to be necessary for such purpose." A physician proceeding on his own decision only that an abortion is necessary acts at his own peril. In the case of *Hatchard v. State*, 79 Wis. 361, the Wisconsin court stated: "Although he may have believed that such necessity existed, yet if in fact it did not exist, he is not exonerated. This is the plain reading of the statute."

If the operation is advised by 2 physicians other than the one performing the abortion as necessary to preserve the life of the mother, it would seem to be a complete defense. In all such cases physicians are advised to proceed only when such advice, in the form of written statements, is furnished for inclusion with the patient's record.

After-Treatment

The position of the physician called to treat a patient suffering from the results of an attempted or completed abortion is a difficult one, and may be precarious as well. Not infrequently the abortionist merely starts the procedure, advising the woman to consult her own physician for all future care. It may sometimes be difficult for the physician to identify criminally-induced cases, as distinguished from cases with natural causes, since most women are hesitant to make such an admission. If the woman dies, suspicion may well turn to those near at hand, and the innocent physician may find himself involved in unfortunate publicity as a result of his attendance on the patient at the time of death.

Physician Consultant; Statement by Patients

When a physician is confronted with this type of case, he can, and should, insist that at least one other physician be called in before treatment is given. Preferably, and for obvious reasons, the consulting physician should not be one associated with the attendant physician. Their joint testimony as to the woman's condition would almost invariably negative the charge that procedure used in the course of treatment was itself the activating cause of the abortion or miscarriage.

In an emergency case, when no other physician is available, it is proper to insist that the patient sign a written statement, in the presence of witnesses, if possible, reciting the facts concerning the

performance of the abortion and including the name of the abortionist. The necessary treatment should then be given only after an understanding that the physican may use the statement in event he later requires it for his protection. In every instance complete, detailed patient records should be maintained.

In *State v. Law,* 150 Wis. 313, a physician called to treat a woman after an abortion refused to take charge of her unless she made a full statement concerning the abortion, which he insisted upon for his own protection and to enable him to institute proper treatment. The Supreme Court of Wisconsin said: "It was a very proper request for him to make under the circumstances." Thus there is judicial recognition, by the highest court in Wisconsin, that it is proper for a physician to take precautionary steps to protect himself in such a situation.

Necessity of Reporting Case

The Wisconsin legislature, in its 1947 session, enacted Section 366.20 of the Wisconsin Statutes which requires in part that *all* physicians immediately report to the sheriff, police officer, or coroner of the county within which occurs a death following an abortion, when such a death is within a physician's knowledge. Noncompliance is a misdemeanor, punishable by fine or imprisonment. Although there has been no judicial interpretation of this new requirement, it is the opinion of legal counsel that it is intended to apply *only* to those situations in which the mother dies following an abortion and not to the destruction of a fetus.

The prudent physician will adopt safeguards over and above the statutory requirements in such cases. When consulted by a woman who has been treated by an abortionist, the physician should try to insist upon a complete disclosure by the patient to proper authorities, although this is frequently difficult if not impossible to accomplish. The woman obviously wishes to conceal her condition and its cause, and not infrequently does so until death.

What should the physician do under such circumstances? Primarily, his duty is to his patient, and he should do the best he can for her up to the time it seems probable that she will die as a result of a criminal abortion or miscarriage. At that stage, it would seem advisable to afford the district attorney a chance to obtain a statement from the patient. No harm can come from such a procedure, for if the patient dies, the physician is bound to report the cause of death, and then he must either disclose the fact on the death certificate that the patient died of an artificially-produced abortion, or he must accept the responsibility for being an accessory-after-the-fact by concealing the cause of death. If the patient dies, and it becomes known either through the physician's death certificate or otherwise that a criminal abortion is suspected, the part the physician played in the case will become a matter of public notoriety in connection with any inquest that may be held, and the physician's reputation will be subjected to suspicion at the least. People will wonder what motive he had for failing to give the prosecuting attorney the opportunity of obtaining a dying declaration.

IDENTIFICATION BY BLOOD TEST

Whenever relevant to the prosecution by the mother, or defense by the alleged father, in an illegitimacy action, the trial court may order the mother, child and alleged father to submit to one or more blood tests to determine whether the defendant can be excluded as the father of the child. The results of the test are admissible only to prove that the defendant is not the father; the results of a test which show only that the defendant might be the father are not admissible. Such tests are conducted by a physician or physicians, licensed to practice medicine and surgery, or by another duly qualified person or persons, not to exceed three, who are appointed by the court and paid by the county. Sec. 52.36, statutes.

Whenever relevant in a civil action to determine the parentage or identity of any child, person or corpse, the court may direct any person or persons involved to submit to one or more blood tests under restrictions and directions deemed proper by the court. Only where definite exclusion of the person involved in the controversy is established by the test are its results receivable in evidence. Sec. 325.23, statutes.

Discarding Case Records and X-Rays

HOW long should you retain your case records after professional services to your patient have ended? When can you safely discard roentgenograms? As records accumulate through the years and storage becomes an increasing problem, these questions become ever more important.

Professional records of physicians are generally considered to be the property of the physician who makes them. There are limitations upon this property right, of course. Professional case records are held by the physician subject to the right in the patient that they be kept confidential. Ethical considerations require that they be made available to a succeeding physician upon the request of the patient.

Subject to those limitations, the physician has a clear property right in his professional records and x-rays. His legal right to destroy them in the absence of statutory restriction follows from his ownership of them. As a matter of professional judgment, however, such records should not be destroyed so long as they have any conceivable value either to the physician or to the patient. It is suggested that each record, then, be individually evaluated before destruction.

State and federal narcotic laws require physicians to retain narcotic records for specified periods of time, usually two years. Severe penalties, including revocation of narcotic licenses, may be imposed for failure to comply with this requirement. If the Wisconsin physician keeps such records as are prescribed by the State Board of Health, he will meet the requirements prescribed by both the Wisconsin and the federal statutes.

Certainly professional records should be kept as long as they may be of value to the physician or his successor in the treatment of the patient at subsequent times. This is, of course, a moral rather than a legal requirement. It is clear, however, that there are many situations in which a premature destruction of professional records and x-rays could operate as a disservice to the patient and could result in great harm.

Professional records should be retained over the period of time in which the physician's treatment and diagnosis may be a matter of concern to the patient in the prosecution or defense of a legal action or in the establishment of some legal right. The establishment of a service-connected disability in a claim against the Veterans Administration, the determination of mental capacity in a will contest, the evaluation of personal injuries in an automobile accident, the extent of disability resulting from an industrial accident in a claim under the Workmen's Compensation Act, are examples of legal actions in which professional records are of substantial importance to the patient.

The controlling considerations in determining how long professional records should be retained for these purposes are the statutes of limitations fixing the time in which legal action must be brought. Mental incapacity, infancy, and various other factors may enlarge this time, however. It is therefore recommended that if the physician has any reason to suspect that professional records may have legal value to the patient, he consult the patient before destroying them.

The importance of records in the defense of malpractice claims cannot be overemphasized. Professional records and x-rays should be preserved over the period of time necessary to protect the attending physician and the hospital if it is involved, insofar as any claim for malpractice may be concerned. Wisconsin statutes require that one alleging a claim of malpractice must assert that claim either by institution of legal action or by the filing of a formal notice with the physician in a manner prescribed by statute within two years of the occurrence of the alleged event. This applies even to those who may be incapacitated by reason of infancy or insanity.

Even where no suit has been filed or notice given within two years, the patient may still raise the matter of malpractice as a defense to an action by the physician to collect fees. A collection suit will not then revive a patient's right to damages, but the lapse of that right will not keep him from arguing that the services were so far below standard as to be non-compensable. Such a collection action must be commenced within six years and, thus, if the physician considers that it may become necessary to resort to legal action in the collection of his fee, it would be well to retain his professional records for at least that six-year period.

It is apparent from the above that no general statement can be made as to the length of time professional records should be kept. In the absence of statutes such as the narcotic laws, the obligation of a physician to preserve his records appears to be a moral rather than a legal one, and he incurs no liability as such for failing to keep them. Certainly, however, it is clear that the welfare of both the physician and his patient is best served if careful consideration is given each case record before destruction.

Access to Hospital Records*

Some Legal Aspects

A PERPLEXING problem which confronts hospital administrators is the determination of a proper policy with respect to access to hospital records. What about permitting inspection of or furnishing or permitting the making of copies of hospital records of a patient? What should be commonly recognized as the ethical obligations of the hospital to its patients? The hospital occupies a confidential position with respect to its patients analogous to that occupied by the attending physician. It would be illogical for the physician to be bound professionally to keep inviolate information acquired in his professional capacity and yet to permit the same information, reduced to the case record of the patient, to be disseminated indiscriminately. The proper approach, it would seem, is not to determine the question in the light of what liability, if any, is assumed by the hospital in permitting access to the records of a particular patient but rather to view the matter in the light of what duty, if any—legal, ethical, or moral—there is on the hospital to permit access in any particular case. Few decisions of courts of appellate jurisdiction—usually the only courts whose decisions are available in the published reports—can be found that are squarely in point for the purpose of the present discussion. General principles, then, seem to be the only basis from which to carry on the discussion.

On principle, it would seem that a hospital retains case records for a twofold purpose: (1) It retains them as a trustee, or in some other confidential capacity, for the patient and the attending physician and (2) it retains them as evidence of the care and attention its own servants rendered in the case. If, then, a hospital retains case records as a trustee or in some other confidential capacity for the patient and his attending physician, in theory it can make no use of those records except, of course, in defending itself from charges of negligence inconsistent with the rights and interest of the patient and the attending physician. Strictly from the patient's point of view he is entitled to privacy; that is, he has the right that the nature and incidents of his illness be not subjected to public view but only to the view of those who are acting for him and in his interest.

This general rule may be altered possibly in any particular instance by the presence of (1) some specific local law or ordinance on the matter,[1] (2) some express contract between the hospital and the other interested parties or (3) some express hospital regulation or possibly local custom on the subject, concerning which the patient and the attending physician had actual or implied knowledge.

There must necessarily be excepted from any extended discussion instances in which any of the qualifying factors just noted are present. Obviously a general statement with respect to such situations is impossible because of unpredictable factual setups. For instance, we cannot anticipate the exact wording of a state statute or a local ordinance with respect to a governmental hospital that would permit general access to the records concerned. Nor can we hypothecate a discussion on conceivable hospital regulations or local customs with respect to the matter; furthermore, if there is an express contract entered into between the hospital, the patient and the attending physician with respect to the future use of the records concerned, the terms of that agreement, of course, will govern.

Of the qualifying factors mentioned, the most common will be instances in which some state statutes or local ordinance in specific language denominates the records of a governmental hospital as public records. The very concept of a public record

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* This article, by T. V. McDavitt of the A.M.A., was reprinted, with permission, from the Journal of the American Medical Association, May 2, 1942. The article has been checked against the 1953 *Wisconsin Statutes*, recent Wisconsin judicial decisions and Opinions of the Attorney General. No Wisconsin law has been found inconsistent with the context of the article.

[1] No attempt has been made in preparing this article for republication to check local ordinances, but the following Wisconsin statutes are examples of local law on this matter:

(1) Section 48.44 (3) requires maternity hospitals to maintain, on forms prescribed by the Department of Public Welfare, a complete record of every patient and her infant for the period of hospital care for pregnancy, birth, and two weeks after birth. But Section 48.44 (4) forbids direct or indirect disclosures of the contents of the records by any person connected with the maternity hospital, "except in a judicial proceeding . . . or for the information of the state board of health, the state department of public welfare, or the local health officer." Section 48.44 (4) then goes on to say that it in no way limits or modifies the physician-patient privileged communications statute, Section 325.21 (See Article on Physician, Patient, and the Professional Secret, page 41.)

(2) Section 48.45 (2) requires a maternity hospital to report cases of illegitimacy to the State Department of Public Welfare.

(3) Section 142.03 (3) (c) requires any hospital to whom a crippled child has been judicially committed for treatment to make report to the Crippled Children Division of the State Department of Public Instruction at the time of the discharge of the patient. The report must contain not only identifying data, but also a description of the disability, treatment given, recommended aftercare, and "such other information as said department may require."

(4) In addition to the above, there are, of course, numerous statutory sections requiring reports where patients are receiving care at public expense.

implies generally a right on the part of the public to inspect on demand. Even if there is such a statute or enactment relating to a particular governmental hospital, however, it must not be assumed that any person is legally entitled to access to the complete records of that hospital. There may be reason to draw some distinction between the right of the public to view the records maintained for or relating to administrative purposes and the public right to view that portion of the record maintained for pathologic purposes, the clinical records. Furthermore, even if there is an enactment of this type, if there is also a statute prohibiting physicians from disclosing in court information acquired in attending a patient, it is quite generally held that a governmental hospital cannot be compelled to grant access to its records to a third person *(Massachusetts Mutual Life Ins. Co. v. Board of Trustees of Michigan Asylum for the Insane* (Mich.), 144 N. W. 538) and that such records if subpenaed in court are not admissible in evidence over the patient's objection. *(Davis v. Knights of Honor* (N. Y.), 58 N. E. 891; *Sovereign Camp v. Grandon* (Neb.), 89 N. W. 448; *Smart v. Kansas City* (Mo.), 105 S. W. 709.)[2]

Coming then to the more common situation in which there is no law or enactment requiring a hospital to grant access to its records, nor any express contract relating to the matter, nor any hospital regulation or local custom that might govern the matter of access. Under such circumstances there seem to be no legal grounds on which it might be contended that any person, except possibly the patient or his attending physician, has a right of access to the records, unless by virtue of a subpena where those records are presented in court or before some administrative tribunal. The only persons, it would seem, who can be said to have any legal right of access to a particular case record are the patient, his attending physician or some one designated by the patient to act in his interest. It is not altogether clear that even the patient has a legal right to such access, but in view of the fact that the hospital in its compilation and custody of the record of a particular patient is acting as a trustee, in part, for the patient, the patient's interest should govern the hospital's conduct, and the primary question should not be, Has the patient an enforceable legal right to inspect the records? but rather, What good reason is there for denying his access? The patient may have an immediate interest in such records, either with a view to litigation or with a view to subsequent treatment: to that extent he may be harmed by a refusal to permit him or his representatives to inspect or copy the records. On the other hand, if the records have been properly kept and the case properly treated, neither the hospital nor the attending physician has any real interest in denying access. In any event, if litigation occurs, the production of the records in court or before some tribunal can be compelled.

In many instances an attending physician may desire access to records with respect to a previous hospitalization of his patient during which the patient had another attending physician. In such an instance it would seem that access should be granted to the present attending physician; clearly so when the patient authorizes the hospital to do so. Even in the absence of such express authorization by the patient, access should be granted on the theory that when a patient places himself under the care of a physician he authorizes that physician to use such measures as are necessary to diagnose his condition and to determine and pursue the proper course of treatment, and obviously the records with respect to a previous hospitalization may often be of material aid to the attending physician. If a patient specifically objects to his attending physician viewing the record, the safest course for the hospital would seem to be to act in accordance with the patient's wishes.

Thus far I have discussed what seems to be the proper policy when the patient or some one acting in his interest seeks access to the records. What then should be done when access is requested or demanded by persons other than the patient or his representatives? A hospital is under no obligation to permit anyone, save possibly the patient, his representatives and the attending physician, to examine or copy records of a given patient unless such examination is required by a valid statute, ordinance, regulation or an appropriate court order. For the protection of the hospital, evidence of proper authority from the patient should be required of everyone, other than the patient and the attending physician, who desires access to the records in a given case, before permitting an examination of such records. Claim agents, attorneys and representatives of insurance companies, unless accompanied by the patient, should be required to present written authority from the patient before access is allowed.

Probably the most frequent request or demand for access to hospital records comes from representatives of insurance companies. An insurance company is not entitled to such access even though it has insured the life, limb or health of a patient. This is true even though the insurance policy involved requires the patient to furnish the information the insurer seeks, for even then the insurer should seek such information from the patient and not from the hospital. Although a contract of insurance contains express or implied authority for a hospital to give out such information, the hospital is not a party to the contract and cannot safely accede to what appears in the policy to be the patient's consent to access. It is a safer practice to require, as a condition precedent to access, the written consent of the patient, dated as nearly as possible to the date access is desired. If the patient refuses to sign a consent at that time or refuses to obtain the desired information for the insurance company, certainly the hospital has no right to do so on its own account.

[2] An opinion of the Wisconsin Attorney General of May 3, 1946, indicates that this rule would apply in Wisconsin. See 35 O.A.G. 116.

Cases may arise that require a hospital to deviate from the rules that have been stated and to assume the responsibility of giving information without the consent of the patient, as where the patient is unconscious, delirious or seriously ill so that he himself cannot supply the information but the information is essential to the procuring of some immediate benefit to the patient or to those dependent on him. The proper officer of the hospital may then assume the responsibility, recognizing it as a responsibility; but, generally speaking, in such a case the law would presume the consent of the patient as to what is definitely for his benefit.

Finally, the question often arises as to the right of a hospital either to lend its hospital charts for research work or to use them in staff conferences or other clinical study. Whether the patient's right to privacy should yield to some extent to the cause of medical science, I am not prepared to say, as no legal authority can be found that would permit a hospital to make such use of its case records. The universality of the custom among hospitals in permitting such use of its case records may or may not have a bearing on the question.[3] In any event, the least the hospital can do is to require the consent of the attending physician and to insist that the case records be used and presented in such a way as not to reveal the identity of the patient or of the attending physician.

Of course, nothing that has been said here has reference to the making of reports required by law. Where the law requires a report to be made of a birth, of a communicable or industrial disease, of a crime or of a death, that report must be made, and the law will protect the maker. Such a legal requirement would also doubtlessly protect a hospital in the making of most, if not all, of the reports required by workmen's compensation acts.

This discussion, as noted earlier, has dealt with the right of a demandant to secure access to the hospital records of a particular patient, and no discussion has been given to the liability of a hospital for making an improper, unauthorized disclosure. Conceivably such a liability could be imposed on a hospital, though no case is known in which a court has held a hospital liable for damages for the unauthorized disclosure of hospital records.

In conclusion, the procedure followed in permitting access to a patient's record should conform to the standards of conduct which physicians have prescribed for themselves with respect to the sanctity of confidential communications. A patient cannot well be denied the privilege of access to his own records, nor may this privilege be denied his attending physician, his attorney or any other person acting with his authorization and in his interest. Furthermore, such access should not also be dependent on the written consent of the attending physician. No other person should be accorded access to the records, however, without the patient's written permission, and this rule should be rigidly enforced as against claim agents, insurance adjusters and attorneys. Any other policy would certainly serve no useful purpose for the hospital.

The accompanying form to evidence the patient's consent to access to the hospital records by a particular person is submitted for consideration. Certainly, if the execution of such a consent is required before access is permitted and if the executed form is presented by the hospital, the hospital is in a formidable position as against any potential liability to its patient, and, in following the procedure just suggested, could also rest secure in the knowledge that its actions had been in accord with the highest medical ethics.

Consent to Access to Hospital Records

To_____[insert name of hospital superintendent] _____hospital

I) hereby authorize and request you to furnish
We)
a copy of the hospital records of _____

[insert name of patient] or to allow those records

to be inspected by_____[insert name of grantee].

I) hereby release_____hospital and
We)
you personally from all legal responsibility or liability that may arise from the act

I) have authorized above.
We)

Signature of patient_____

Other signatures_____

_____

Date_____

Witness_____

NOTE.—The signature of the patient alone should be sufficient in all cases except when the patient is a minor or is incompetent, in which cases, in addition to the patient's signature, the signature of the parents or surviving parent or guardian, respectively, should be obtained.

Explanation.—This form when duly executed should be attached to the hospital records of the patient, with a notation as to the date on which the records were viewed or copy was furnished.

No particular form is suggested for a patient's request to be furnished a copy of or to be allowed to inspect his own records. Such a request, however, should be in writing and should be attached to the records with the notations indicated just above.

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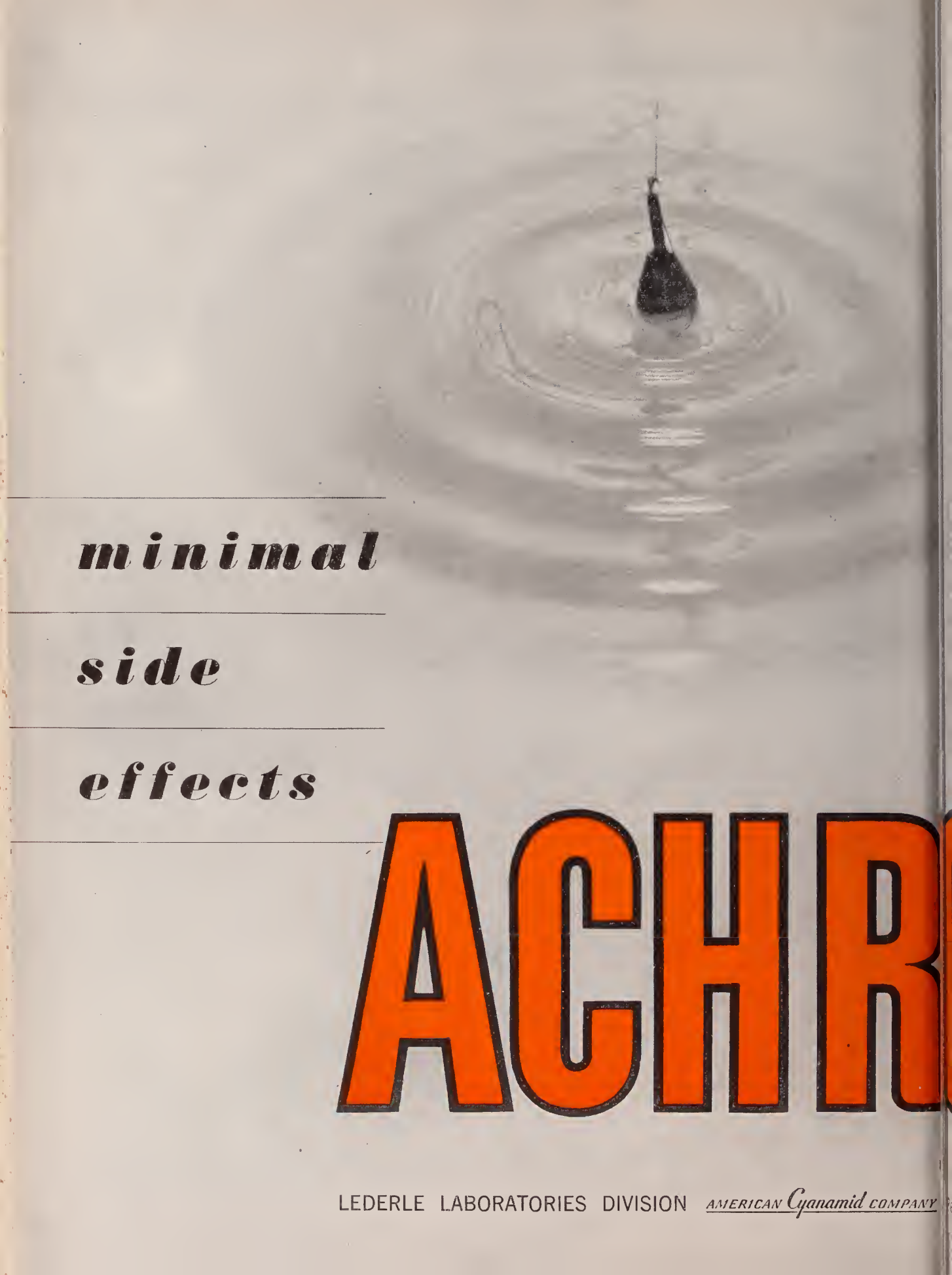
[3] Section 46.21 (2) (b) of the *Wisconsin Statutes* specifically authorizes the use of county hospitals and sanitariums for purposes of medical and nursing education, and to "assist the application of science to the alleviation of human suffering."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The Physician's Will and Estate

EVERY physician owes the duty to his wife and family to plan the disposition of the estate which he has built up during his years of practice. Primarily, such planning deals with problems regarding the disposition of his estate at the time of death. It also includes certain transactions which take effect during his lifetime.

The need and desirability of planning, including the execution of a proper will, is discussed in this article. Briefly such planning is necessary (1) to prevent the operation of the intestacy laws, (2) to eliminate guardianship over the property of minors, (3) to prevent substantial depletion of the estate by ignoring tax saving devices, (4) to provide expert investment and management of the estate after the physician's death, and (5) to take care of any specific bequests which a physician may wish to make. Each of these is discussed more fully in the paragraphs which follow. In addition, care must be exercised that sufficient liquid assets are available to the estate for administrative costs and death taxes so as to avoid forced sale of property.

Some physicians may feel that their estate is too small to bother about planning its disposition. Most physicians have at least a small bank account, a few bonds or securities, household furniture, an automobile, and life insurance policies. Such an estate probably amounts to several thousand dollars. Many also own an equity in a home. Many of the reasons set forth in this article pointing up the necessity of a will apply just as well to the small estate as to the larger one. Furthermore, in the small estate, every dollar counts in so far as the surviving widow and children are concerned and care should be taken that these few dollars do the most adequate job possible.

When the physician arrives at the attorney's office to discuss his estate planning and will drafting, he should be prepared to present to the attorney a complete itemization of all of the assets owned by himself and members of his family, indicating the ownership of each asset, their original cost, and approximate present value. In addition, his life insurance policies should be left with the attorney for his examination and recommendations regarding settlement options, qualification under the marital deduction, and possible changes in beneficiary designations. In this connection it might be wise to arrange for the attorney to discuss the life insurance policies with the physician's life insurance agent. While life insurance generally passes independently of the physician's will, it is nevertheless included in the assets which become available upon a physician's death and must be included in the physician's estate for death tax purposes.

Prevention of Intestacy Law Operation

In the absence of a will, the intestacy laws will govern the distribution of a person's estate. In Wisconsin, this means:

1. *If widow and two or more children survive,* one-third of the real and personal property passes to the widow and the remaining two-thirds is divided equally among the children. Where the deceased person owned a homestead at the time of his death, the widow has the right to use it until her death or remarriage. This homestead right is in addition to the one-third share which the widow takes outright.

2. *If widow and one child survive,* the widow again has the right to use the homestead until her death or remarriage. In addition, the widow is entitled to take one-half instead of one-third of the personal property. In so far as real property is concerned her share remains at one-third. The surviving child takes therefore one-half of the personal property and two-thirds of the real property and the remainder interest in the homestead.

3. *If widow alone survives,* and no issue of any deceased children survive, the entire estate passes to the surviving wife.

4. *If children, but no widow, survive,* the entire estate passes in equal shares to surviving children and issue of deceased children.

Certainly in the case of a young physician, the distribution in accordance with the Wisconsin intestacy laws, placing ownership of at least one-half of the estate in his children, would work a definite financial hardship on his widow.

It would seem that in most cases the bulk of a young physician's estate should be left directly to his widow or in trust for her and her dependent children's benefit so as to insure to her the greatest financial means and security during the years when she must take care not only of her own support but also that of her fatherless minor children. It is true that if property comes into a minor's possession that the income therefrom and the principal amount if needed can be used for the support of the minor child. As is pointed out, however, in this article under the heading "Elimination of Guardianship" the use of such funds is fraught with many complications, leading many observers to consider such use of minor's funds more theoretical than practical.

In this age of automobile and airplane travel, there is always the chance that husband and wife may be killed in a common disaster. In this case, the physician's estate should benefit his minor children. However, even in this situation guardianship should be avoided and in most cases a trust presents

a more satisfactory and flexible solution to the problem. Again a will is necessary because such a trust cannot be created otherwise than by will. This is discussed more fully under the heading "Elimination of Guardianship."

In the case of physicians who no longer have minor children some situations might present themselves in which distribution in accordance with the intestacy laws would carry out the testator's intentions. In most cases, however, his wishes to provide first for his widow veto such a method of distribution. Furthermore, a physician who no longer has minor children is generally middle-aged or more and has accumulated more than an average estate. Such a physician will need a will, if for no other reason than to prevent death taxes from materially reducing his plans and intentions for his widow and adult children following his death. It is possible, through a properly drawn will, to sharply reduce taxes and at the same time carry out substantially the testator's desires and intentions regarding his wife and children and other objects of his planning.

A physician whose intent, in so far as the distribution of his estate is concerned, coincides with the intestacy law of descent is the exception rather than the rule. This is true of young, middle-aged, or old physicians.

Elimination of Guardianship

Care should be taken to avoid the placing of property outright in the name of a minor. In some cases, it is highly desirable to grant ownership rights in property to minors. In those cases, however, serious consideration should be given to the trust device of ownership during the minority of the child.

In all cases where property descends to minors under the intestacy laws, it does so absolutely and in the name of the minor outright. Inasmuch as the law presumes the inability of minors to manage and protect their property, a guardian subject to court direction must be appointed. In effect, another estate proceeding is commenced in the county court. The widow may be appointed guardian of her own children, but she must provide a surety bond and pay the premium. Furthermore, an annual accounting must be made to the county court.

None of the principal amount of the minor's estate can be used by the widow or other guardian without first getting permission from the court. This means that every time the widow wishes to use a portion of the minor's estate, petitions and court orders must be prepared and presented to the court, thus entailing the employment of an attorney.

Furthermore, no portion of one minor's estate can be used for the benefit of another minor child. There are situations, for example, serious and prolonged illness, where from the widow's standpoint this might be desirable. In fact, it would undoubtedly have been the wish of the deceased husband that the wife use her own judgment in apportioning and using the principal in accordance with the needs of the several children.

Power of the guardian to invest minors' funds is strictly limited to low income producing securities. In effect, the majority of the investment is limited to government securities. Not only is the interest rate low, but government securities are fixed in amount and cannot, therefore, keep pace with inflation.

In all cases where it is desirable to have property pass to minor children, it is strongly recommended that trusts be created by will. Properly drawn trusts can give to the trustee discretionary power to use both income and principal for the minor's welfare. In addition, a "sprinkler" trust can be created, vesting in the trustee power to apportion and use principal and income for the several children in accordance with their varying needs.

A trust can also be so drawn as to give the trustee power to invest in preferred and common stocks, thus providing greater income and greater capital gain possibilities.

A guardianship ceases when the minor attains the age of 21 years. Oftentimes it may be advisable to withhold payment until the child has reached a more mature age. This can be done only through the trust device.

Tax Savings

If the physician's estate, including life insurance and the entire amount of joint property, exceeds $60,000, considerable death tax savings can be effected by proper planning, without substantially disturbing his desires and intentions regarding his wife and children and other objects of his bounty.

Marital Deduction. The Revenue Act of 1948 introduced the marital deduction concept into the field of estate planning. It applies only to the federal estate tax and has no bearing whatsoever upon Wisconsin inheritance tax. In effect it provides that a person may leave to his surviving spouse one-half of his property, including joint property and life insurance, tax free. The remaining one-half is considered the decedent's estate for federal estate tax purposes. From this one-half is subtracted the specific exemption of $60,000. The balance is subject to tax.

For example, a net estate of $120,000 will pay no estate tax if the marital deduction is utilized, since the first $60,000 is tax free under the marital deduction and the specific $60,000 exemption offsets entirely the $60,000 remainder of the estate. If the marital deduction is not used, the tax on the estate of $120,000 is $9,500.

If the net amount of the decedent's estate is $200,000, the difference in tax payable is $27,900.

The entire estate can be given to the widow. Only one-half is eligible, however, for qualification under the marital deduction.

The portion of an estate which passes to the wife under the marital deduction will, of course, be subjected to tax upon the death of the wife, assuming her estate amounts to more than $60,000. The ques-

tion therefore presents itself whether it would not be wise to leave the entire estate in trust, giving the wife the income therefrom during her life and paying the principal to the children upon her death. However, assuming the marital deduction is used, the combined taxes on the two estates (husband's and wife's) are still substantially less than the tax would be if computed on the entire estate of the husband. The answer is therefore no.

This is so because tax rates become progessively higher as the size of the estate increases. If the estate can be split into two smaller portions (as is done when the marital deduction is used) two $60,000 exemptions are made available. Also the higher tax rates are avoided because the lower tax rates are used twice in computing the taxes on the combined estates.

Much of this saving, due to utilization of the lower tax rates, will be lost, however, upon the death of the wife in those cases where the wife has a substantial estate in her own right.

Because of tax savings possible in most cases through use of the marital deduction, common disaster provisions in wills are also discouraged.

Four methods may be used to take advantage of the marital deduction. They are (1) an outright bequest to the wife; (2) a trust, all the income of which is payable to the wife for life and the principal payable to her estate; (3) a trust, the income of which is payable to the wife for life together with a right in the wife to appoint the principal as she may choose during her life or by her will, and (4) a legal life estate to the wife under which the wife is entitled to the income for life with a right in her to appoint the remainder interest as she may choose during her life or by her will.

Most property, including life insurance and joint property, can be used to qualify under the marital deduction.

In most estate plans, substantial savings can result through use of the marital deduction. Great care must be exercised by the drafter of the will that the technical requirements of the Internal Revenue Code are met when attempting to qualify property under the marital deduction. If life insurance is sought to be qualified under the martial deduction, the settlement options must be carefully worded.

Saving the Second Tax. If the entire estate of the husband is given to the wife, an estate tax will be payable on the entire amount so inherited at the time of her death. In effect, this means that as to the one-half portion of the husband's estate which did not qualify under the marital deduction two estate taxes will be paid—one at the time of the husband's death and the other upon the wife's death.

It is therefore recommended that the husband strongly consider giving to his wife the marital deduction share of his estate, and placing the remaining one-half in a separate trust, the income of which can be paid either to the wife for her life or accumulated for, or distributed to, their children in the discretion of the trustee. In either event, the principal of such trust should be paid over to the children upon the death of the wife or on their attaining a certain age. In this way, a tax will be paid on this portion of the estate only in the husband's estate, none being due at the time of the wife's death, since she had no interest in this portion subject to tax.

This tax saving device applies to Wisconsin inheritance tax as well as federal estate tax.

It might be well to point out here another objection to holding property in joint tenancy. Since such property passes independent of will, it can never escape the second tax unless it be included in the property making up the marital deduction.

Income Tax Savings By Creation of Second Trust for Children. In those cases where the estate is sufficiently large so as to enable the wife to maintain herself adequately from the income and principal of the marital deduction share, substantial annual income tax savings can result by splitting the non-marital deduction one-half of the estate into separate trusts for each child. In this way the income from such trusts will not be taxed, at top income tax rates, to the widow, but will be taxed as several separate entities, each utilizing the lowest possible income tax rates.

Gifts During Lifetime. By making gifts of portions of your estate during your lifetime, it is possible to avoid paying any federal transfer tax. The transfer may be subject in part to a Wisconsin gift tax, but the savings in federal estate tax far outshadow the small Wisconsin tax.

In effect, the federal tax laws allow a husband to give away tax free a basic amount of $60,000 during his lifetime. *In addition,* he may annually give away $6,000 to *each donee* without federal gift tax liability. These amounts are conditioned upon either the gift being to the wife or the wife consenting to the gift. If either of these conditions are not met, the amounts are $30,000 and $3,000 respectively.

Problems may arise where the physician seeks to make gifts to his minor children. The obstacles are not insurmountable. It will suffice to point out in this discussion that should such gifts be contemplated, competent counsel should be sought.

It is in the field of making lifetime gifts that the greatest savings of transfer taxes can be accomplished. Each physician of some means should give serious thought to this possibility.

Not to be overlooked when considering the possibility of lifetime gifts is the possible income tax saving. Since ownership of the property made the subject of the gift is no longer in the physician, the income will no longer be taxed to him but to the recipient. Inasmuch as the recipient will probably be in a lower tax bracket than the physician making the gift, savings will result. Furthermore, if substantial gifts to children are contemplated, the income will be divided into separate tax entities, each being able to use the lowest rates as con-

trasted with the fact that the income would be taxed at the top tax bracket in the physician's return were it still his income.

If a physician has a choice of assets which can be made the subject of gifts, it is desirable not to give away assets which have appreciated in value since they were acquired. This is so because on a sale of such assets by the recipient, his income tax cost basis would be only the original cost of the giver, whereas if the giver died owning such assets and the recipient acquired the assets through the estate of the giver, the assets would pick up the market value at time of the giver's death as their income tax cost basis.

Likewise, where assets have depreciated in value, and are of the type which can be readily repurchased, the giver can save income taxes by selling the assets and taking a loss which is deductible on his income tax return. He can then make a gift of the proceeds with which the recipient can repurchase the assets sold. Listed stocks which have depreciated in value are good examples of this type of asset.

Specific Bequests

A will is necessary in every case in which the physician wishes to provide specifically for a person or institution other than his wife and children. For example, if the physician wishes to leave a gift to charity or to a faithful employee, such bequest can be made only by a provision in a will.

A word of caution should be given regarding gifts to charities. Care should be exercised that the exact legal name of the charity is used, and the use which the charity is to make of the bequest, if any special one is desired, should be carefully spelled out.

Expert Investment and Management of Estate

In the absence of a will, or in a will which provides that all of the property is payable outright to the wife or children, the property undoubtedly will not be as well managed or invested as was the case during the physician's life. It is generally recognized that the average widow is not equipped by training, experience, or temperament to be a shrewd investor or manager of property.

Where the amount of the estate is sizable, serious consideration should be given to placing the bulk of the estate in one or more trusts. Of course, the trustee should be carefully chosen so as to secure for the physician's wife and children expert management and investment. Many of the banks in the larger cities throughout the state have trust departments employing full time personnel, trained in and doing nothing but the management and investment of trust estates. The average physician would do well to discuss the matter, including costs, with his local or nearby trust company.

Life Insurance Proceeds

In the estates of many physicians, and certainly in the estates of most younger physicians, life insurance constitutes the largest single asset. It is important, therefore, that the planning of the disposition of these proceeds be integrated with the planning regarding the other assets. Life insurance proceeds can be paid (a) in a lump sum to the beneficiary, (b) in fixed installments over a period of years, (c) to a trustee of a life insurance trust created during lifetime, or (d) to the estate of the insured.

Payment in a lump sum has the obvious disadvantage of placing the burden of management and investment upon persons generally not trained or experienced in this field.

Payment can be made to the insured's estate and thus let the proceeds be disposed of along with his other assets in accordance with his last will and testament. While this manner of disposition might seem desirable, it has serious disadvantages; namely, subjecting these proceeds to attorney's and executor's fees and subjecting to inheritance tax the first $10,000 of proceeds which would otherwise be exempt from such tax.

Generally speaking, the insurance should either be placed in a life insurance trust or left with the insurance company to be paid out by it in periodic installments. In the latter situation, a fixed amount, neither rising nor falling with inflation or deflation, will be payable each month, quarter, or year, bearing a guaranteed interest yield.

In the case of a life insurance trust, the insured during his lifetime executes a trust instrument having as its sole purpose the payment of the life insurance proceeds to the trustee named in the instrument. The procedure for this is quite simple. The trust instrument recites that it may be revoked or amended at any time during the insured's lifetime and sets forth provisions to govern the administration of the trust from and after the receipt of the insurance proceeds. It will be necessary, in order to activate this revocable trust, to deposit with the trustee a nominal sum (*e.g.*, a $25 war bond), which will, for the time being, be the only trust asset.

A trust fund will rise and fall with prosperity and depression. On the other hand, family needs tend to go up and down proportionately. Trusts will tend in normal times to earn more than the guaranteed yield on most insurance policies.

One other distinction between life insurance trusts and the leaving of proceeds with the insurance company to be paid out periodically should be discussed. In the latter situation, a fixed amount is payable on each installment date. The widow can, in most cases, be given a right to withdraw an additional amount at any time so as to take care of emergencies or other unusual needs. In a trust, the discretion to pay out additional funds is generally fixed in the trustee. Some physicians may prefer their widow rather than outsiders to have this discretion as to

when needs of the family require extra payments out of principal; others may prefer the trustee to exercise this discretion.

Joint Tenancy

Many individuals are under the mistaken notion that the placing of one's property in joint tenancy with one's wife is a substitute for a will. As has been so often said, joint tenancy is a substitute for a will in about the same sense as a size 34 suit will fit all men. It will fit some men but not others. In the first place, joint tenancy always makes imperative the execution of wills by both husband and wife. A joint tenancy always involves a gamble as to who dies first. In many cases husband and wife may die within a short time of each other. Therefore, in order to insure the distribution of the estate upon the death of the surviving joint tenant in accordance with the desires of the parties, wills for both husband and wife become necessary.

Secondly, a will has no effect upon joint property. Such property passes automatically to the surviving joint tenant. In many cases, the physician would want his estate placed in trust so as to gain the benefit of greater flexibility and expert management and investing of funds. This is impossible with regard to joint property.

Joint tenancy also has tax implications. It is commonly thought that when a person dies holding property in joint tenancy that only one-half the value of such property is included in the estate for inheritance and estate tax computations. This happens to be true for Wisconsin inheritance tax purposes. It is not true, however, for federal tax purposes. The federal tax authorities have ruled that regardless of whether a valid gift was made during lifetime of a joint tenancy interest and regardless of whether a gift tax was paid, the entire value of the joint property will be included in the taxable estate of the person who furnished the money for the acquisition of the property. In most cases, this will mean the physician himself.

This problem arises, of course, only where the estate is subject to federal estate taxes, namely an estate in excess of $60,000. Those physicians whose estates are presently less than this amount are not, of course, faced with the problem. Certainly, however, most physicians can anticipate accumulating substantially more than this amount during their lifetime, and therefore should bear this in mind when acquiring property of any type.

It is recommended that physicians hold their property either in their own name individually or in the name of their wife individually, or as tenants in common. The term "tenants in common" is distinguished from "joint tenants" in that property held as tenants in common passes by will or by operation of the intestacy laws, whereas joint property passes independently to the surviving joint tenant. In so far as the federal tax laws are concerned a tenant in common suffers no penalty.

In the case of those physicians who presently hold property in joint tenancy, consideration should be given to changing ownership of the property from themselves and their wives as joint tenants to themselves and their wives as tenants in common. This can be done without incurring additional gift tax liability.

Estate planning is in essence an effort to make equitable and prudent disposition of whatever property a physician has been able to acquire. It is one of the most important pieces of planning that a physician or other person does. It calls for competent and sympathetic advisors. At the very least he will need an insurance counsellor and an attorney. If his affairs are large enough to warrant it, and in particular if he has to consider alternative courses of action, he will also need the assistance of a professional accountant, an investment counsellor and an experienced trust officer, all working as a team.

EPILEPTICS AND THE STATE MOTOR VEHICLE DEPARTMENT

No one who is subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin, except under the following conditions:

If an epileptic is under medical care, however, and while under medication is free from seizures, and his driving is not otherwise a hazard to public safety, he may be issued a temporary license, which must be recertified each six months. Section 85.08 (6) (j) of the Wisconsin Statutes, enacted during the 1949 session of the Legislature, provides that any physician licensed in this state may recommend such a temporary license for a patient on a combined questionnaire and recommendation form provided by the Motor Vehicle Department.

The issuance of a temporary license, predicated upon such a recommendation by the physician rendering treatment, is discretionary with the Motor Vehicle Department, but a denial may be reviewed by a special board, two of the three members of which are designated by the president of the State Board of Health.

YOUR DEADLINES AND OTHER "MUSTS"

Below are some of the deadlines and "musts" of a practicing physician:

Taxes.

1. File your Wisconsin and federal income tax returns as early in 1955 as possible, *but not later than March 15* for the Wisconsin return and April 15 for the federal return.
2. By January 15, 1955, you must pay the final installment of estimated 1954 tax. By this date you must have paid at least 80 per cent of the tax which will be actually due for 1954. If it appears that you will not be within 80 per cent, you may file an amended declaration for 1954 by January 15, 1955, and pay an amount sufficient to bring you within 80 per cent. In lieu of such amended declaration, you may make your federal tax return on that date and pay the full balance due.
3. By January 31, you must:
   (1) File the employer's final return of income taxes withheld in 1954 on Form W–3.
   (2) Furnish a statement to employees on Form W–2 showing wages paid and amount of tax withheld during the calendar year 1954.
   (3) File fourth quarterly return for 1954 of income and social security tax withheld on wages paid employees on Form 941:
      a. If entire tax not paid by timely depositary receipts.
      b. If less than $100 withheld in each of October, November, and December 1954.
   (4) Pay income and social security taxes withheld on 1954 wages to employees:
      a. If more than $100 withheld in December 1954, and not paid to government depositary earlier in January 1955.
      b. If less than $100 withheld in each of October, November, and December 1954.
4. (1) If instructions contained in paragraphs 3 and 4 of Section 3, preceding, are applicable to your situation, make similar quarterly payments and returns on April 30, July 31, and October 31 for the respective preceding calendar quarters.
   (2) If the instructions contained in paragraphs 3 and 4 of Section 3, preceding, are not applicable to your case; in other words, if the total of income and social security taxes withheld on employees' wages exceeded $100 a month and timely deposits for that purpose were made in each of the three preceding months, a quarterly return on Form 941 is due and should be filed on February 10, May 10, August 10, and November 10.
   (3) If income and social security taxes withheld on employees' wages exceed $100 in either the first or second months of each calendar quarter, the amount thereof should be paid to a government depositary by the fifteenth of the following month. The amount of such withheld taxes for the last month of each quarter may either be paid the month immediately following or by the tenth of the second month after the ending of such calendar quarter, as earlier set out in these instructions.
5. The first quarterly estimate of your own income for 1955 is due on April 15. Further estimates are due by June 15 and September 15 of 1955 and January 15, 1956. A final return filed before January 31, 1956, will be treated as the equivalent of an amended declaration as of January 15.

   Penalties are provided for underestimating and therefore underpaying taxes on declarations of estimated taxes to the extent that each quarterly installment is under 70 per cent of one-fourth of the tax due for the year, shown on the filed return. A penalty of 6 per cent computed on the amount of the declaration of the underpayment is added to the tax. The penalty can be avoided if the estimated tax is based upon the previous year's income and on the basis of the current year's rates and exemptions, or on the previous year's tax, whichever is the lesser. The penalty can be avoided in still another way. You annualize your income up to the end of the month preceding the installment due date. You then compute the tax on this annualized income. If the installments paid to date are equal to at least 90 per cent of 25 per cent, 50 per cent, 75 per cent, or 100 per cent of the tax, as the case may be, no penalties are payable.

Annual Registration in Wisconsin; Annual Narcotics Registration

1. Register with the Secretary of the Wisconsin State Board of Medical Examiners in the month of January. This registration will be on a form furnished by the Board of Medical Examiners.
2. Register as required by the federal narcotics law, and pay the annual tax *before* July 1, 1955. You are subject to penalties for overlooking either the registration or the tax.

Change of Residence:

1. Notify the collector of internal revenue to insure the legality of your narcotics license. Penalties are imposed for failure to do this.
2. If you take up residence in another county, record your license and basic science certificate with the county clerk so that no question will arise as in the collection of your fees, or your right to give testimony in a legal proceeding.

Remember to:

1. Make prompt report to the State Board of Health of cancer cases, communicable diseases and others as described in the article on page 87.

2. File with the city health officer or county register of deeds a certificate for all births attended by you within five days of the event. Otherwise your medical fees are unlawful. Sec. 69.30, statutes.
3. Register with the county judge if you desire reference work on commitment proceedings for persons allegedly insane, epileptic, inebriate, mentally deficient, and drug addicts. Registration is limited to physicians who have practiced for two years, or have had one year's experience in a hospital for the mentally ill. Sec. 51.01 (2), statutes.
4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), statutes.
5. Report immediately to the local health officer in writing the name, age, and address of every person diagnosed as afflicted with "epilepsy or similar disorder characterized by lapses of consciousness." Section 146.23 (2), statutes.
6. Report *immediately* the following deaths, as required by Section 366.20, statutes, to the sheriff, police chief, or coroner of the county in which such death occurred:
   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.
   e. All deaths due to poisoning, whether homicidal, suicidal, or accidental.
   f. All deaths following accidents, whether the injury is or is not the primary cause of death.
   g. When there is no physician in attendance.
   h. When a physician refuses to sign the death certificate. See page 51.

PHYSICIANS ADVISED ON SUBSTITUTION OF SILVER NITRATE

Attention has been directed to the fact that some Wisconsin physicians are reporting on birth certificates the use of penicillin as a substitute for silver nitrate in the prevention of opthalmia neonatorum. While there has been some discussion in professional circles regarding the efficacy of substitutions for silver nitrate, the Committee on Maternal and Child Welfare has expressed the opinion that to date there is insufficient evidence to support such action. Physicians are urged to subscribe to the procedures clearly set forth in the Wisconsin Statutes, which reads:

> "146.01 Infant Blindness: (1) For the prevention of opthalmia neonatorum, or blindness in the new born babe, the state board of health shall, annually, cause to be prepared and put up in proper containers a one per cent solution of nitrate of silver with instructions for its use. These shall be distributed free to local health officers in quantities sufficient to enable them to, and they shall, deliver one to each physician and midwife. The attending physician or midwife shall use the said solution as directed in said instructions.
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> * * *
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> "(3) Any person who violates this section shall be fined not more than one hundred dollars."

On the basis of present procedures set up through the State Board of Health, and the reliable services of the State Laboratory of Hygiene in supplying solutions of correct strength and freshness, it does not appear advisable to the Committee on Maternal and Child Welfare to suggest revision of the Wisconsin statutes at the present time.

Until such time as the wording of the law is changed, physicians are warned to avoid the use of any substitute for silver nitrate in the prevention of opthalmia neonatorum, as violation of the statutes subjects a physician to a possible fine, as indicated, and may subject him to a suit for malpractice.

The position adopted by the committee concurs with that of the American Medical Association as was stated in an editorial which appeared on page 123 of the January 12, 1952, edition of the Journal of the American Medical Association.

THE MEDICAL FORUM

300 Interns Given Deferments for Residency Training

Washington, Dec. 17.—The Defense Department has selected a total of 300 interns for deferment for 1-year residencies in 15 medical specialties essential to the military departments. Their names were drawn by lot recently from among more than 1,300 non-veteran interns who asked for further deferment under the new Armed Forces Reserve Officer Commissioning and Residency Consideration Program. (See November Forum, page 593.)

The remaining 1,000 interns who failed to be selected are subject to induction after next June under either the regular draft or the doctor draft, depending on what action the next Congress takes on the law. Both the regular and the doctor drafts expire June 30.

Under the Defense Department-Selective Service program, questionnaire statements of service preference were sent all 1954 medical school graduates who had been deferred from induction to complete their medical education plus one year's internship. Of the more than 1,800 replies, some 1,300 asked for residency deferment, while 560 preferred to accept reserve commissions and enter their 2-year tour of duty within the year following completion of internships next spring.

Dr. Bowers

CLOSED-CIRCUIT MEDICAL TELECAST TO BE SHOWN IN MILWAUKEE

Milwaukee, Jan. 10.—Milwaukee is one of 32 major cities throughout the country which will receive "Videclinic," a special closed-circuit medical telecast presented by the American Medical Association, on February 9. The broadcast, a clinical report on heart disease, will be shown at 7:45 p.m. in Milwaukee's Pfister Hotel on a large-sized screen erected especially for the program.

Coronary artery disease will be the phase covered in the TV clinical study. Featuring 12 speakers from 9 different states, the program will include live telecasts, "remote pickups" from medical centers, and film presentations. The telecast will originate from New York.

The Medical Society of Milwaukee County will act as host to physicians throughout Wisconsin who wish to attend the telecast. Designed as a TV clinical conference, the program is sponsored by the AMA in cooperation with Smith, Kline and French Laboratories in an attempt to bring medical information quickly to doctors from coast to coast. The program is one of the largest mass education closed circuits yet attempted.

The Milwaukee Society is also devoting its regular monthly meeting in February to a discussion of heart disease. On February 10, the Society will present a special symposium on "The Management of Acute Myocardial Infarction," with Drs. W. B. Youmans, Madison, F. Janney Smith, Detroit, and William Brams, Chicago, as speakers.

NAME DR. BOWERS DEAN OF U. W. MEDICAL SCHOOL

Madison, Dec. 18.—Dr. John Z. Bowers, dean of the University of Utah College of Medicine, has been appointed dean of the University of Wisconsin Medical School.

Dr. Bowers will suceed Dr. William S. Middleton, dean of the Wisconsin Medical School since 1935, who will retire next July 1.

Dr. R. G. Arveson, Frederic, chairman of the State Medical Society Council, and the head of the Board of Regents committee which interviewed prospects, announced that the selection was unanimous. Formal confirmation of Dr. Bowers' appointment was made at the Board's January meeting.

BECAME YOUNGEST DEAN

The 41-year-old physician has been dean of the Utah medical school since 1950 when he became the youngest dean in the school's history. During his tenure, he has guided the development of a program of post graduate medical education for the school and has become widely known as an administrator. During that time he has also made two trips to India under commissions from the Ford Foundation to study conditions and to make recommendations for health programs.

SERVED ON AEC

A specialist in internal medicine, Dr. Bowers has been deeply interested in radiobiology, particularly radiation tolerances. He was chief of the Medical Branch of the Biological and Medical Division of the Atomic Energy Commission in 1947–48 and deputy director of the division from 1948 to 1950. Since assuming his post at Utah, he has served as medical consultant in biology and medicine to the director of the AEC.

At Utah, he established the University's Radiobiology Laboratory and has carried on research projects under grants by the AEC.

A native of Cantonsville, Md., Dr. Bowers received a bachelor of science degree from Gettysburg (Pa.) College in 1933 and obtained

(Continued on page 75)

A recent gift to the collection of historic medical objects of the State Historical Society is this mortar and pestle, the property of Dr. Galen Rood of Stevens Point, who died in 1917. Made of cast iron, the mortar and pestle were donated by Donald E. Gill, Madison, a grand nephew of Dr. Rood.

Dr. Rood was born in 1830 in Vermont, moving to Madison in 1842. He read medicine with Dr. C. B. Chapman and graduated from Ohio Medical College in 1856, opening his office in Stevens Point in June of that year.

Three of Dr. Rood's four children became doctors. These include: Dr. Myron C., Stevens Point; Dr. Price W., Milwaukee; and Dr. Robert D., Bartlesville, Oklahoma.

AMA CREATES GERIATRICS UNIT

Miami, Dec. 2.—At its Clinical Session in Miami, in December, the AMA House of Delegates passed a resolution calling for the creation of an organization on geriatrics within the structure of the Association.

The new unit will develop and assist committees on geriatrics and gerontology in state and county societies and act as a liaison between these committees to insure a free flow of information "between all levels of organized medicine on the subject of geriatrics."

The resolution also named as purposes of the unit: "To make available to the American people such facts, data and opinions concerning the subject of geriatrics as may be considered of value in alleviating social and medical problems created by the increasing population of older age groups; and to perform such other duties as will improve and advance the medical care rendered to people of the older age group."

Schedule Cancer Clinics For Dentists and M.D.'s

Madison, Jan. 15.—Cancer clinics for physicians and dentists will be held in February and March in Sheboygan and Racine. The Sheboygan clinic will be held on February 17 with the program at the St. Nicholas Hospital and dinner following at the Foeste Hotel. The Racine clinic will be held March 3 at the Racine Elks Club.

Faculty members for the Sheboygan clinic will include Drs. W. D. Stovall, Madison, director of the State Laboratory of Hygiene; F. J. Hofmeister, and Joseph Gramling, Jr., both of Milwaukee; and S. N. Bhaskar, D.D.S., Chicago.

NAME PROGRAM SUBJECTS

Subjects covered will be these: "Biopsy Techniques," "Cancer of the Female Genital Tract," "Oral Cancer," and "Cancer of the Colon and Rectum."

The following faculty members will present a similar program at the Racine clinic: Dr. Stovall; Dr. Walter Reich, Chicago; J. M. Gules, D.D.S., Milwaukee; and Dr. James Conley, Milwaukee.

All physicians interested in attending these clinics are urged to register in advance. The only charge is $3.00 for the dinner. All other expenses will be assumed by the Wisconsin Division of the American Cancer Society.

Reservations should be addressed to the Committee on Cancer, State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin.

AMA to Evaluate Acceptance Programs

Chicago, Dec. 31.—The Board of Trustees of the American Medical Association has appointed a special committee to re-evaluate the existing seal-acceptance programs of the AMA's scientific councils. The appointment, naming, as chairman of the committee, Dr. Thomas P. Murdock, Meriden, Conn., was made during the AMA's Clinical Session in Miami in December.

The committee will report its findings to the Board in February. Seals of acceptance are now granted by the AMA's Council on Pharmacy and Chemistry and the Committee on Cosmetics; the Council on Foods and Nutrition; and the Council on Physical Medicine and Rehabilitation.

Bernhart Named Head Of Midwest Conference

Madison, Dec. 20.— Dr. Ervin L. Bernhart, Milwaukee, president-elect of the State Medical Society, will serve as president of the Midwest Medical Association Conference, which will be held in Madison in November, 1955.

The Conference is a meeting of medical society officials from the states of Michigan, Illinois, Indiana, Ohio, Kentucky, and Wisconsin.

The purpose of the Conference is to make it possible for medical society officials in these states to give joint consideration to problems that affect the practice of medicine and the health of the people in a region of the country which has generally similar problems.

More Interns, Residents Now Being Trained

Chicago, Dec. 15.—There are now 75 per cent more physicians in full-time intern and residency training in the U. S. than there were 10 years ago, according to the 28th annual report of the AMA's Council on Medical Education and Hospitals.

In January of 1954, 26,000 interns and residents occupied hospital staff positions, compared to about 15,000 in 1945.

However, during the same period, the number of openings for full-time graduate work has doubled. On January 1, 1954, there were 34,172 openings compared to the 16,095 openings in 1945. As of September 1, 22,763 residencies and fellowships and 11,222 internships were open for the 1954–55 year.

The report pointed out that a fundamental problem exists in that the opportunities for intern and resident service have been increasing more rapidly than the number of available applicants.

In Wisconsin, 201 internships alone were available on January 15, 1954, but only 135, or 67 per cent, were filled. The report stated that 90 per cent of the available positions for both interns and residents had been filled in 1945 while only 79 per cent were filled in the 1953–54 year.

Urge Hospitals, County Societies to Schedule Maternal Mortality Speakers

Madison, Jan. 10.—Eighteen Wisconsin hospitals and one Michigan hospital, as well as two county medical societies, have requested speakers from the Division on Maternal and Child Welfare to discuss the findings of the maternal mortality survey.

The speakers are presenting the findings and conclusions of the survey under the title, "Significant Factors in Wisconsin Maternal Deaths in 1953," and supplementing the factual discussion with slides and charts.

HOUSE RECOMMENDS MEETING

Action of the House of Delegates last October in Milwaukee recommended that "every hospital staff and county medical society hold at least one meeting during 1955 for presentation of the findings and conclusions of the maternal mortality study."

Hospitals and societies are urged to schedule the meeting and request a speaker as soon as possible.

Speakers are furnished without expense. However, as only five sets of slides are available for use, *it is recommended that requests for speaker service be filed at least a month in advance of the meeting date.*

WRITE FOR SPEAKER

In addition, those requesting a speaker are asked to indicate alternative dates, and also to state whether or not they can supply a screen and a projector for showing standard slides (3¼" x 4").

To secure a speaker, write to: The Division on Maternal and Child Welfare, State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin.

The following doctors have spoken on the maternal mortality study or are scheduled to speak during the coming months: Drs. S. D. Austin, Green Bay; Richard Flynn, Milwaukee; Leo Grinney, Racine; Carl Harper, Madison; F. J. Hofmeister, Milwaukee; Carl Hultman, Milwaukee; T. A. Leonard, Madison; Russell Lewis, Marshfield; J. W. McGill, Superior; W. O. Paulson, Eau Claire; Thomas Rice, Marshfield; George Schroth, Wausau; Lee Stevenson, Madison; Dean Willson, Fond du Lac.

The Racine and Portage county medical societies both scheduled meetings for a speaker on the maternal mortality survey.

The following hospitals have scheduled staff conferences on this subject: St. Joseph's, Marshfield; Lutheran, Beaver Dam; Sturgeon Bay Municipal; St. Mary's, Baraboo; Lakeland, Elkhorn; Milwaukee Hospital; St. Mary's, Sparta; Columbia, Milwaukee; Mercy, Oshkosh; St. Michael's, Milwaukee; Victory Memorial, Stanley; Mount Sinai, Milwaukee; Clintonville Community; Doctors, Milwaukee; St. Joseph's, Dodgeville; Holy Family, Merrill; St. Joseph's, Ashland; Burlington Memorial; and St. Joseph's Hospital, Menominee, Mich.

President Requests 2-Year Extension Of Doctor Draft

Washington, Jan. 5.—In his "state of the union" message to Congress, President Eisenhower asked for legislation extending the doctor draft for two years. The present doctor draft law is due to expire on June 30.

Early in December, the AMA House of Delegates, meeting in Miami, adopted a statement of policy concerning the doctor draft law. The House said that "on the basis of current information," it believed that the law should not be extended after June 30, 1955, and it expressed confidence in the ability of the AMA Board of Trustees and its Council on National Defense to "properly handle any new situation which may develop."

Extension of the law has been recommended as a means of continuing authority to keep a file of physician registrants in order to avoid setting up completely new machinery in case of a national emergency.

The AMA statement also directed the Board and the Council to "continue to study the problem of providing the best possible medical service for members of the armed forces," and to "make recommendations to the Department of Defense at the earliest possible time for a more permanent solution to the problem, giving special attention to the further development of a career medical corps with adequate compensation therefor."

FDA Tells of Increase In Medical Quackery

Washington, Dec. 10.—The Commissioner of the Food and Drug Administration, George Larrick, in a speech before the American Pharmaceutical Manufacturers Association, gave warning of an increase in fake medical products and devices. He said his agency cannot do a 1955 job with a 1940 staff and pointed out that sufferers from chronic ailments continue to be the victims of "high-powered hocus pocus research."

Most serious and most tragic exploitation, according to Larrick, is in the field of cancer quackery and he stated that operators in this field are attacking the medical profession. Medical quackery, he added, is using the "big lie" technique to cloak its operations in the guise of legitimate research.

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PROGRAM

TENTH NATIONAL CONFERENCE ON RURAL HEALTH

Sponsored by the Council on Rural Health, American Medical Association

February 24–25–26, 1955

Schroeder Hotel — Milwaukee, Wisconsin

Theme: LOOKING BOTH WAYS

FEBRUARY 24—AFTERNOON

GREETINGS

GOVERNOR'S OFFICE, STATE OF WISCONSIN

GEORGE F. LULL, M. D., Chicago, Illinois
General Manager, American Medical Association

A. J. MCCAREY, M. D., Green Bay, Wisconsin
President, State Medical Society of Wisconsin

LOOKING BOTH WAYS

F. S. CROCKETT, M. D., Lafayette, Indiana
Chairman, Council on Rural Health, American Medical Association

PANEL: FARM AND HOME SAFETY

Consultants: PHYSICIAN; EXTENSION WORKER; FARMER; 4-H CLUB BOY AND GIRL; SAFETY ENGINEER

FEBRUARY 24—EVENING

Rx RECREATION

ROBERT FREIDEL, Milwaukee, Wisconsin
Supervisor, Dramatics and Music, Department of Municipal Research

FEBRUARY 25—MORNING

PANEL: FAMILY RESPONSIBILITY FOR HEALTH

Consultants: PHYSICIAN; HOMEMAKER; FARMER; 4-H CLUB BOY AND GIRL

FEBRUARY 25—AFTERNOON

PANEL: USING OUR PRESENT HEALTH AND MEDICAL CARE RESOURCES

Representatives:
PUBLIC HEALTH; AUXILIARY; MEDICINE; FARM ORGANIZATION; TRAINING FOR GENERAL PRACTICE; EXTENSION SERVICE

FEBRUARY 25—EVENING

DUTCH TREAT DINNER

Reservations necessary. Tickets $3.00

MEDICHOIR

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

RURAL HEALTH AND WORLD PEACE

WALTER H. JUDD, M. D., Minneapolis, Minnesota
Minnesota Congressman

FEBRUARY 26—MORNING

PANEL: SUCCESSFUL STATE RURAL HEALTH PROJECTS

State Projects: MONTANA; WISCONSIN; ILLINOIS; TENNESSEE; WEST VIRGINIA

HOW FAR THAT LITTLE CANDLE THROWS ITS BEAMS

MRS. CHARLES W. SEWELL, Otterbein, Indiana
Advisory Member, Council on Rural Health, American Medical Association

FEBRUARY 26—LUNCHEON

LUNCHEON

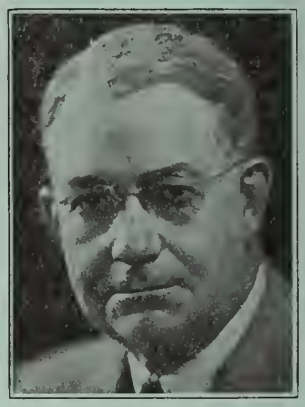
Courtesy, Council on Rural Health, American Medical Association

INTRODUCTION OF SPECIAL GUESTS

KARL B. PACE, M. D., Greenville, North Carolina
General Practitioner of the Year

MRS. GEORGE TURNER, El Paso, Texas
President, Woman's Auxiliary, American Medical Association

LEONARD W. LARSON, M. D., Bismarck, North Dakota
Member, Board of Trustees, American Medical Association



Dr. Crockett

"Medicine is no longer a job for the doctor alone—it is a community problem, too. Through these annual conferences, we have been able to pinpoint the health needs in rural areas all over the country. And the gratifying results can only be accomplished through the excellent teamwork that the health and farm people have produced so far. Our first ten years in this important endeavor of creating more healthful living for people in rural areas has produced a remarkable unity of purpose."

—F. S. Crockett, M. D., Chairman, Council on Rural Health, American Medical Association.

Dr. MacCornack

"Because of the importance of rural health in Wisconsin medicine, the House of Delegates at Milwaukee last October recommended that 'all physicians give their support to the Conference by their attendance and active participation.'

"Every Wisconsin doctor is urged to attend all, or as many of the sessions as possible and to make his contribution to the meeting."

—R. L. MacCornack, M. D., Council on Medical Service, State Medical Society of Wisconsin.

WISCONSIN HOST TO NATIONAL RURAL HEALTH MEETING

Madison, Jan. 10.—Wisconsin will be host to the National Conference on Rural Health for its tenth anniversary meeting, February 24 to 26, at the Schroeder Hotel in Milwaukee. Sponsored by the Council on Rural Health of the American Medical Association, the Conference is expected to draw an attendance of over 500 from professional, farm, service, and educational groups.

Keynoting the meeting will be the theme, "Looking Both Ways." The program has been designed to present a review of past achievements in bettering rural health and to offer an opportunity for constructive planning for the future. As at past meetings, participants will include outstanding physicians and national leaders from farm organizations, 4–H Clubs, community planning councils, educational groups, and agricultural extensions.

NOTED M.D.'S TO SPEAK

Conference sessions will begin on Thursday, February 24, and will continue through Saturday, February 26. Topics for discussion include farm and home safety, family responsibility for health, and effective use of present health and medical care resources.

Two noted physicians scheduled to talk at the meeting are: Dr. Walter H. Judd, Minneapolis, Minnesota congressman, who will speak at the annual dinner on February 25 on "Rural Health and World Peace"; and Dr. Karl B. Pace, Greenville, N. C., 1954 General Practitioner of the Year, who will address the closing luncheon session on February 26.

WISCONSIN GROUPS ON PROGRAM

Dr. A. J. McCarey, Green Bay, president of the State Medical Society, will speak at the opening session of the Conference, together with a representative of the Governor's Office of Wisconsin, and Dr. George F. Lull, Chicago, secretary–general manager of the AMA.

Wisconsin groups will provide several evening programs for the meeting. The featured event of the Thursday evening session will be "Rx Recreation," narrated by Robert Freidel, supervisor of dramatics and music for the Milwaukee Department of Municipal Research. Entertainment at the annual dinner will be provided by the Medichoir, composed of 45 students from the University of Wisconsin Medical School.

One of the highlights of the Saturday morning presentation of "success" stories of health projects in various states, will be the discussion of the emergency rescue squad organized in Marinette County. Joseph Banach, safety director for Ansul Chemical Company in Marinette will present the details. Other discussions will include a 7-state survey of rural health facilities; a weight, nutrition, and health project; and joint community action to secure a doctor.

Participating in the panel on medical care resources will be: Dr. Robert N. Barr, Minneapolis, deputy executive officer of the Minnesota Department of Health; Mrs. Mason G. Lawson, Little Rock, Ark., of the Woman's Auxiliary to the Arkansas Medical Society; Dr. Wyatt Norvell, New Castle, Ky., chairman of the Kentucky State Medical Association's Committee on Rural Health; R. Bruce Tom, Columbus, Ohio, chairman of the Ohio State Grange Health Committee; Dr. J. E. Dudding, Hope, Ind., chairman of the Indiana State Medical Association's Committee on Rural Health; and Gertrude Humphreys, Morgantown, W. Va., home demonstration leader, Agricultural Extension, West Virginia University.

All doctors who plan to attend should clip out the registration coupon on this page and return it as soon as possible to: The Council on Rural Health, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois. Hotel reservations should be made direct to the Schroeder Hotel in Milwaukee

TENTH NATIONAL CONFERENCE ON RURAL HEALTH

FEBRUARY 24–25–26, 1955

SCHROEDER HOTEL, MILWAUKEE, WISCONSIN

Date _____

Please reserve _____ **plates for me at the Friday evening dinner, February 25. (Tickets $3.00 each)**

I shall / shall not **attend the Saturday luncheon meeting, February 26.**

(Luncheon courtesy Council on Rural Health)

Name _____

Street _____

City _____ **State** _____

(Make hotel reservations direct to Schroeder Hotel, Milwaukee.)

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Regional School Health Needs to Be Studied at Milwaukee Meeting

Madison, Jan. 15.—Plans have been announced for the fourth in the series of regional conferences on school health sponsored by the State Medical Society and the State School Health Council. The conference will be held in Milwaukee, on February 10, at the Milwaukee State College.

With a program designed particularly to pinpoint the school health needs of both urban and rural areas, the meeting is expected to interest a large number of physicians, dentists, educators, parents, and public health personnel from the southeastern section of the state. Dr. E. H. Pawsat, Fond du Lac, chairman of the Society's Division on School Health, will preside at the conference.

INCREASE COOPERATION

The conferences are planned to provide increased cooperation between the home, school, and health professions. As in the past, the Milwaukee meeting will be divided into a general morning session and several afternoon workshop discussions. Luncheon will be served in the College cafeteria.

Dr. E. S. Gordon, Madison, professor of medicine at the University of Wisconsin Medical School, and Dr. Thomas Lorenz, Madison, assistant professor of medicine at the Medical School, will give the feature lecture of the morning session, with their discussion of "The Integrated Physical and Emotional Growth of Children."

SCHEDULE HEALTH MOVIE

Closing the morning session will be a color and sound motion picture, "School Health in Action." Produced in Oklahoma, the movie will highlight some of the problems to be covered in the afternoon workshops. The topics for these panel discussions include: health examinations and school health services in metropolitan and in rural areas; special health problems such as nutrition, dental health, diabetes, and rheumatic fever; preventive mental health concepts; referral of emotionally disturbed children; and health aspects of physical education.

A number of physicians will participate in the program as panel members for the discussions. On the health examination panel will be: Drs. Gerald F. Burgardt, Wauwatosa City Health Officer; Paul S. Pierson, Milwaukee; Edward Krumbiegel, Milwaukee Commissioner of Health; F. J. Mellencamp, Milwaukee; Porter B. Blanchard, Cedarburg; A. H. Heidner, West Bend; and Albert C. Edwards, Racine City Health Officer.

Drs. Walter S. Polacheck and Sherburne Morgan of Milwaukee, and Karl Beck, Wauwatosa, will participate in the special health problems panel. The mental health workshop will include Drs. Bernard Kaufman, Milwaukee, James Johnson, Milwaukee County Guidance Center, and John Altmeyer, Milwaukee City Health Department, as panel members.

The panel on referrals includes Dr. Sara Geiger, Milwaukee, and Dr. Harold Schroeder, Racine, of the Racine-Kenosha County Child Guidance Center. Dr. Charles W. Dowding, Milwaukee, member of the Milwaukee Health Department, will serve on the physical education panel.

Dr. Mellencamp is also serving as a member of the Local Planning Committee for the conference. Other physicians on the committee are Dr. Virginia Downes, Milwaukee, and Dr. Margaret Hatfield, Elkhorn.

Safety Conference Held At Milwaukee in January

Madison, Jan. 10.—A number of physicians, particularly those interested in industrial medicine, are scheduled to attend the 13th Mid-Winter Safety Conference and Exposition, January 20 and 21, at the Schroeder Hotel in Milwaukee.

Sponsored by the Wisconsin Council of Safety, the meeting features on its program a discussion of mental health approaches to accident prevention, a special section meeting for industrial nurses, and talks on medical and legal aspects of noise problems, the establishment of rescue squads, highway accidents, and slips and falls in the home.

A representative of the State Medical Society is to discuss the importance of part-time medical services in small industrial plants.

Signing Your Name to Legal Documents

Lawyers find that people are often at a loss to know how to sign their names to legal documents. While signature discrepancies ultimately may be straightened out, the process can be expensive.

The law defines a name as a word or words used to distinguish and identify a person. Under common law, since very early times, a legal name has consisted of one Christian or given name, and one surname which is the family name. The law presumes every man to have a given name, unless the contrary is shown, and it must be stated in full on legal documents. For this reason, the law does not pay too much attention to the middle name or initial. However, it is wise to use the middle name or initial since it may be important for purposes of identification. There is a growing tendency to give more importance to the middle name and in a few jurisdictions it is held to be a material part of the name in civil as well as criminal actions.

The law does not consider "junior" or "senior" a significant part of the name, as it does not consider Mr. or Mrs. to be of importance. The abbreviation of Jr. or Sr. or "the second" added to a name is generally considered to be a mere matter of description used to distinguish between two or more persons with the same name, especially when they live in the same community.

(Editors Note: This column is one of a series prepared by the Wisconsin Bar Association. It is intended to inform not to advise. Facts may change the application of the law.)

New Members Appointed To Study Committee On Maternal Mortality

Madison, Dec. 1.—Drs. Frank Gruesen, Fort Atkinson, George Kilkenny, Milwaukee, and Carl Harper, Madison, have been named to the Study Committee of the Maternal Mortality Survey.

The appointments were made by Dr. Robert Purtell, Milwaukee, chairman of the State Medical Society's Division on Maternal and Child Welfare, under which the study is being conducted. At its November meeting, the Division approved continuation of the survey and voted to replace two members of the Study Committee each year, beginning in 1955, to provide opportunity for wider physician participation.

Dr. Gruesen replaces Dr. E. D. Wilkinson, West Allis, and Dr. Kilkenny replaces Dr. F. J. Hofmeister, Milwaukee. Dr. Harper was appointed to replace Dr. John Harris, Madison, who had resigned because of illness.

Dr. T. A. Leonard, Madison, continues as chairman of the Committee. Other members are Drs. R. J. Sanderson, Beloit, and Alice Watts, Milwaukee.

DR. BOWERS . . .

(Continued from page 69)

his medical degree from the University of Maryland in 1938.

He served as a commander in the Navy during World War II. He is married and the father of three children.

Dr. Bowers is a past vice-president of the Association of American Medical Colleges and is, at present, a member of the executive council and chairman of the editorial board.

He is a member of the American Medical Association, the American College of Physicians, and the Association for the Study of Internal Secretions as well as other scientific groups.

Dr. Bowers' written work ranges from studies of irradiation injury to the use of television in medical education.

Commenting on the appointment, A. Matt Werner, Sheboygan, president of the Board of Regents said, "I'm sure Dr. Bowers will fit in very well with our Medical School. I think he will make a fine dean."

PROPOSE GUIDE FOR PROGRAM OF SCHOOL VISION SCREENING

Madison, Dec. 16.—Preliminary approval has been given to a guide that will facilitate the development of a school vision screening program on a state-wide basis. The action was taken at a meeting of the Commission on State Departments of the State Medical Society. Final approval is up to the Council of the Society.

The outline by the commission sets up a desirable method of indicating significant visual defects among school children. It describes the major steps to be taken in the organization and development of a vision screening program to coordinate the efforts of the county medical society, public health nurses, health officers, optometrists, and representatives of schools and parents.

In addition, the guide recommends the establishment of a professional advisory committee to select the method of screening, establish standards, and evaluate the program as it continues.

Annual vision screening of school children is recommended. As a minimum program, grades 1, 4 and 7 should be screened annually. Selection of the method of screening is left entirely to the local community and is based entirely on local resources. The outline also sets up a plan for referring children with unsatisfactory vision tests for further eye examination and refraction. A program similar to the one recommended by the commission's Division on Visual and Hearing Defects has been operating in Dane County for four years and has not resulted in unnecessary referrals, according to reports.

Members of the Commission on State Departments who attended the meeting were: Drs. T. W. Tormey, Jr., Madison, chairman; H. A. Anderson, Stevens Point; Maxine Bennett, Madison; Henry A. Sincock, Superior; E. H. Pawsat, Fond du Lac; Ray Piaskoski, Wood; A. M. Hutter, Fond du Lac; H. W. Carey, Lancaster; and E. D. Schwade, Milwaukee.

Drs. M. C. Borman, Milwaukee; Robert C. Parkin, Madison; and John Doolittle, Madison; and Mrs. Lucille Graves, Madison, Dane County public health nurse, attended as guests of the commission.

Representing various state departments were: Dr. E. H. Jorris, State Board of Health; Mr. John Tramburg, Department of Public Welfare; Messrs. Clarence Greiber, Adrian Towne, and J. A. Kubiak, Department of Vocational and Adult Education and the Rehabilitation Division; and Messrs. R. F. Lewis and Frank Powell, Department of Public Instruction.

Dr. Borman urged that there be a link between the State Medical Society and the Wisconsin Association for Mental Health. He said there was need for medical support to help secure public funds and need for medical guidance in the development of the Mental Health Association's programs. The Council of the State Medical Society will be asked to approve these plans.

Dr. Pawsat announced a special project which the Division on School Health hopes to undertake in cooperation with Professor Robert Francis of the Department of Physical Education of the University of Wisconsin. The project is a study of physical training procedures and practices in Wisconsin schools. The proposal grows out of the belief that many coaches are engaging in dangerous practices directly related to medical care, such as the injection of Novocain in joints as a result of sprains.

Dr. Hutter said that the Division on Geriatrics is developing a guide for the establishment of nursing homes. It is hoped that this guide can be completed prior to July 1 which is the date by which nursing homes seeking federal funds must comply with certain standards.

MAGAZINE SUBSCRIPTIONS

Through the *Wisconsin Medical Journal*, physicians can obtain subscriptions for almost any general magazine at the agent's price, a reduction from the current subscription rate. If you wish to order subscriptions, you may write the *Wisconsin Medical Journal* for the proper rate and on receipt of this advice, issue your check to the *Wisconsin Medical Journal*. *The Journal* staff will order the subscription for you through the magazine agency.

Public Health Council Becomes Corporation At December Meeting

Madison, Dec. 17.—The Wisconsin Public Health Council became a corporation when its Board of Directors met on December 17 in Madison. Formal filing of the Council's Articles of Incorporation and its revised Constitution and By-Laws was carried out during the meeting.

Seven state organizations had accepted the Council's invitation to become charter members at the time of incorporation. These include the State Medical Society, Wisconsin Conference of Catholic Hospitals, Wisconsin Heart Association, Wisconsin Hospital Association, Wisconsin Pharmaceutical Association, Wisconsin State Dental Society, and Wisconsin State Nurses Association.

MEMBERSHIP PENDING

Still considering the Council's invitation at that time were the Wisconsin Association for the Disabled, Wisconsin Anti-Tuberculosis Association, Wisconsin Division of the American Cancer Society, Wisconsin Association for Mental Health, and Wisconsin Division of the National Foundation for Infantile Paralysis.

The setting up of charter memberships, with dues of $100 annually, was one of the major changes voted by the members of the Council at their annual meeting last June in Madison. The decision to incorporate was also taken at that time as part of the extensive reorganization of the Council.

CHANGE DUES, VOTING

Under the reorganization, the classifications of membership were redefined and several new categories were set up with changes in dues and voting privileges. Charter memberships were created, on an invitational basis, for major state-level professional groups and voluntary health agencies. Smaller state organizations, local groups, and local health councils may continue to join for annual dues of $5. Individual dues were dropped to $1 per person. Provision was also made for the receipt of larger grants from foundations and industries.

At the December meeting, the existing executive committee was named as the initial Board of Directors of the Corporation. The Board scheduled the 1955 annual meeting of the Council for the end of February, to be held in conjunction with the National Conference on Rural Health.

Members of the new corporation's Board of Directors include: Miss Edith Bangham, Madison, president; Deane Bascom, West Bend, first vice-president; Palmer Daugs, Lake Mills, second vice-president; Dr. Allan Filek, Madison, treasurer; and C. H. Crownhart, Madison; C. W. Kammeier, Milwaukee; R. A. Mason, D.D.S., Milwaukee; Dr. M. W. Stuessy, Brodhead; Mrs. Caryl Vigdahl, Viroqua; and A. F. Wileden, Madison.

Outstanding 4-H Leaders Receive "Today's Health"

Madison, Nov. 20.—Twenty-two 4-H Club leaders will receive a year's subscription to *Today's Health*, given by the State Medical Society in recognition of the outstanding health promotion projects they have developed with their clubs during the past year. The clubs were chosen as winners in their respective counties by the State 4-H Club leaders at the University of Wisconsin on the basis of club reports on their health and safety programs.

Each club designs its program as a group activity to encourage both individual and community improvement of health. The projects stress such things as medical examinations, TB check-ups, milk and water sanitation, and home and community safety.

Miss Agnes Hansen, Assistant 4–H Club Leader, is in charge of the state-wide 4–H Club Health Program.

Miss Hansen

The following are the club leaders together with the clubs and the counties they represent: Mrs. Carl Tutor, Washburn, Friendly Valley Club (Bayfield); Mrs. Elmer Schaefer, Alma, Jahns Valley Club (Buffalo); Mrs. Henry Muench, Bloomer, Pleasant Valley Club (Chippewa); Mr. and Mrs. E. C. Haslow, Chili, Chili 4-H (Clark); Mrs. Milton Bliss, Hartford, Toland Troopers (Dodge); Mrs. Lillian Zahn, Eau Claire, Badger 4-H (Eau Claire); Mrs. William Lauper, Hollandale, Moscow Center Club (Iowa); Miss Ardell Lenz, Salem, Wheatland Willing Workers (Kenosha); Mrs. Alois Schmitt, Bangor, Adams Valley Club (La Crosse); Mrs. Al Koeppel, Phlox, Phlox 4-H (Langlade); Mrs. Joseph Welnicke, Reedsville, Reedsville Tip Top Club (Manitowoc); Mrs. John B. Walters, Marinette, Ferndale Aces, (Marinette); Mrs. Ernest Janssen, Oconto, Couillardville Club (Oconto); Mrs. Al Hooyman, Neenah, Willing Workers (Outagamie); Mrs. Joseph Hames, Sr., Waubeka, Waubeka 4-H (Ozaukee); Mrs. William Heise, Ellsworth, Club Victory Badgers (Pierce); Mrs. B. Bosman, Baldwin, Pine Lake Polywogs (St. Croix); Mrs. Albert Peissig, Stetsonville, Liberty Club (Taylor); Mrs. Frank Gough, Eagle River, Lucky Lincoln Club (Vilas); Mrs. James Harth, Jackson, Jackson Happy Hour Club (Washington); Mrs. C. E. Butler, Sussex, North Lisbon Lucky Seven (Waukesha); Mrs. Henry Luebke, Oshkosh, Howlett Hustlers (Winnebago).

Ethics Code Amended On Patents, Copyrights

Miami, Dec. 2.—The Principles of Medical Ethics of the American Medical Association was amended by the Association's House of Delegates during its Miami meeting in December on the subject of physician patents and copyrights.

Section 7 of Chapter I of the code was changed to read as follows: "A physician may patent surgical instruments, appliances and medicines or copyright publications, methods and procedures. The use of such patents or copyrights or the receipt of remuneration from them which retards or inhibits research or restricts the benefits derivable therefrom is unethical."

Physicians and the Workmen's Compensation Act*

The 1953 legislature liberalized the Workmen's Compensation Act in a number of respects. Because these changes do not affect the professional relationship of panel physicians and beneficiaries under the act, or modify either the method of making medical reports or of computing disability, they are not added to the article.

THE workmen's compensation act is designed to afford a measure of protection to the working men of the State of Wisconsin. The law, not applicable to farmers, affects employers who, in the course of a business, trade, profession, or occupation, have three or more employes. Benefits are provided an employe sustaining an injury or disease in the course of his employment. It has been stated frequently that all but the employer and the employe are strangers to the act and are unaffected by its provisions. Strictly, this is true. However, when a workman files a claim before the Industrial Commission alleging that he is entitled to benefits under the workmen's compensation act, the commission acquires functions that affect the relationship of the physician and his patient as well as the lawyer and his client.

As has been pointed out previously, many more physicians are constantly coming into contact with the procedures and practices of the Industrial Commission, and because inquiries are frequently directed to the State Medical Society regarding the act and the scope and effect of its provisions, this statement is prepared as a summary of some of the more important aspects of the law. While it has not been drafted by or at the suggestion of the Industrial Commission, it has been submitted to the commission and incorporated in it are the thoughts and suggestions of its staff members.

The panel system. In addition to establishing the "open panel" system assuring free choice of physician for Wisconsin workmen, the agreement executed between the State Medical Society and the insurance carriers created a conference committee composed of both physicians and insurance company representatives. It is important that members of the State Medical Society avail themselves of the services of that committee as an arbitration medium.

The committee functions to reduce the differences that may arise between insurance companies and physicians relating to the method of treatment of an injured workman, the charges made by a physician, and similar questions. Conversely, the insurance companies have the opportunity of referring to the conference committee for arbitration situations in which insurance company officials may be of the opinion that the physician's charges have been excessive or in which the physician has neglected to supply the company with the information to which it is properly entitled.

No formality is required in the cases where either the physician or the insurance companies may have a matter to report relative to the handling or disposition of compensation cases. The secretary of the State Medical Society should be informed of the general nature of the complaint and further information, if necessary, will be acquired that the committee may function to the best advantage possible.

Under the law, of course, the employer is required to post the panel physicians available for treatment just as it is primarily his duty rather than that of his insurer, if he has one, to provide medical care. If the employer fails to do this, the effect of certain supreme court opinions is to hold that the injured workman has absolute free choice of physician. The medical panels of those employers whose insurance is carried by insurance companies participating in the open panel agreement with the State Medical Society are made up only periodically, and so far it has not been necessary to revise these oftener than once each year. A physician who desires to participate in panel listing and who is not now listed may apply to the Society. In applying to the Society, the physician agrees that if he is listed on the panel and engages in treating compensation cases, he will call a consulting physician into the case upon request of the insurance carrier. [It is expected that the physician will communicate with the insurance carrier as to the choice of consultant.]

The members of the State Medical Society should keep in mind that the effort of their Society and the insurance carriers is to provide physicians able and willing to treat compensation cases and to assure to those workmen entitled to the benefits of the act what amounts to a free choice of attendant.

Benefits of the act. The workmen's compensation act is an attempt to provide injured employes reasonable recompense for injuries or diseases received during the course of their employment and to provide them with such medical attention as may be necessary to accomplish the utmost in rehabilitation. The law imposes a liability upon the employer to provide certain indemnities and to provide or pay for necessary medical attention. Because it is in the nature of a liability, those concerned with the compensation act, while they are liberal in its construction, must find three essential elements to

* Reprint (with some corrections and alterations) of pamphlet issued by State Medical Society, June 15, 1940, to its membership. For much of the material the State Medical Society is indebted to Mr. Harry A. Nelson, Director, Workmen's Compensation, Wisconsin Industrial Commission.

exist in order to justify an award to the injured claimant: (1) employer-employe relationship; (2) employer subject to the act; and (3) injury or disease suffered or acquired in the course of employment. With reference to medical care, the workmen's compensation act provides that employers subject to the act must supply any injured employe with "such medical, surgical and hospital treatment, medicines, medical and surgical supplies, crutches, artificial limbs and appliances . . . as may be reasonably required to cure and relieve from the effects of the injury. . ."

Collection of physician's account. It is important to keep in mind that there may be one of two, or two, sources from which the physician may be paid for his services rendered an injured workman entitled to benefits under the act. If the employer himself authorizes the physician to treat the injured workman, then the employer is directly liable to the physician for the expense of that treatment, and that liability continues until such time as it is terminated by the employer's objection to further medical care at his expense.

If, on the other hand, the injured employe himself requested the treatment, without authorization from the employer, then the physician must look to the injured employe for payment, except ordinarily he can expect the Industrial Commission to determine the amount thereof for which the employer is responsible. Where the employer fails to furnish a panel, the injured employe has complete free choice, and the Industrial Commission has power to determine the reasonable necessity for treatment and the reasonable amount of the medical bill for which the employer is responsible. In cases where the employe has not given notice of necessity for treatment or has refused to accept a panel physician, the employer has no liability and the commission no jurisdiction to determine necessity or reasonableness but may, upon claimant employe's request, direct payment to the physician of what appears to be a reasonable amount for necessary treatment.

Physician-patient relationship maintained. Generally, of course, communications to an attending physician are privileged and may not be communicated by him. The workmen's compensation act creates an exception to the general law of privilege as any physician, having attended an injured employe who files a claim under the workmen's compensation act, may be required to testify before the commission when it so directs. With reference to this the commission says: "It is a practical necessity that the physician attending the injured workman furnish information to the Commission upon which to base compensation. Physicians will not be required, however, to disclose confidential communications commuted to them for the purpose of treatment and which are unnecessary to a proper disposition of the claim. The Commission regards the physician who treats the injured workman at the request of the employer, to all intents and purposes, the physician of the injured man. His testimony before the Commission should be absolutely fair and unbiased."

The physician acting as expert witness for injured claimant. Not infrequently, of course, the claim of an injured workman that he has suffered injury in the course of his employment for which he is entitled to compensation is disputed by the employer or the compensation carrier of the employer. The members of the State Medical Society have no interest, of course, in the technical questions of fact and law which involve other than medical questions. They are interested, however, (regardless of whether they may be the attending physician or an expert witness for either the injured workman, or the employer or his insurance company) in the fact that the basis of any claim must depend upon whether the injury or disease was suffered in the course of employment.

In many cases the fact of the injury or disease being suffered in the course of employment is accepted by the employer or the insurance company, and the question then is confined to the extent of liability on the part of the employer. In the fields of industrial disease, or diseases attributable to a given occupation, the physician must be prepared to relate the disability to the employe, if such be the case.

Where the claim is controverted by the employer or insurance company either as to causative factor or as to extent, the injured workman frequently calls upon a physician other than the attending physician to appear as an expert witness in his behalf. In such case, the physician must make a careful study and examination of the whole question and be prepared to present his opinion adequately and carefully.

The State Medical Society has received many inquiries raising the question of how the expert witness is paid and to what extent. Before discussing this question in its many implications, certain basic concepts of the workmen's compensation act must be kept in mind. Of primary consideration the claimant must first establish: (1) the employer-employe relationship with both employer and employe subject to the act, and (2) the fact of an injury or disease sustained or acquired by the claimant in the course of such employment.

Second, as stated elsewhere in this memorandum, the employe is entitled, in event of injury and an award therefor, only to recompense for the injury and for the cost of treatment. The award may not be frivolous or capricious and is governed by the strict formula provided in the act itself. The award, or the jurisdiction to grant one, does not involve the unlimited field of a personal injury action but is strictly governed by statutory limitations.

In the third place, it is conceived as the function and responsibility of the Industrial Commission to protect the injured claimant in every proper way. For example, the law does not provide that appli-

cants must be represented by attorney in hearings before the commission, but that they may appear in person or by agent or attorney. When they appear without attorney, the commission undertakes to do everything possible to assure a fair and impartial hearing. By statute it is provided that an attorney may not charge more than 20 per cent of the amount at which a claim shall be compromised or of the amount awarded, adjudged or collected. However, in cases of admitted liability where there is no dispute as to amount of compensation due, and in which no hearing or appeal is necessary, the fee charged shall not exceed 10 per cent and in no case more than $100 of the amount at which the claim shall be compromised, or of the amount awarded, adjudged, or collected. The commission is authorized, in the interest of a fair and impartial hearing, to order examinations by physicians who are wholly independent of either the claimant, the employer, or the insurance carrier. Such physicians become witnesses of the State of Wisconsin at the time they appear to testify relative to the claim of the injured workman.

Finally, the commission directs attention to the case of Philler v. Waukesha County, 139 Wis. 211, to the effect that expert witnesses may not require payment in excess of statutory fees unless work is performed in preparation at the request of a party. The question frequently arises as to whether a physician must obey a subpoena when ordinary witness fees only are paid. Many physicians believe that they cannot be required to do so unless an expert witness fee is paid to them. Our court, however, has held that except as there may be a demand for preparation, etc., every witness, whether expert or otherwise, must obey a subpoena upon payment of ordinary witness fees.

Because it so frequently deals with the question of physicians' fees, both those in connection with treatment in the case or as an expert, the commission and its staff tend to establish certain levels in the professional work of such physicians. In the case of physicians who are called by the commission as independent expert witnesses or for the purpose of simply making an examination and report, the Industrial Commission has an established fee schedule under which the services are rendered. This fee schedule is set out under rule 13 and is as follows:

> "Unless otherwise specifically agreed, services of physicians and surgeons rendered at the request of the Commission shall be understood as contracted for on the following terms:
>
> Minor examination and report, not to exceed ..... $ 5.00
> Major examination and report, not to exceed 10.00
> X-rays where necessary to foregoing examination and report, not to exceed an additional 5.00
> Attendance at hearings on request of Commission:
> for first hour 10.00
> for each additional hour 5.00
>
> Claims for such services must be paid from the Commission's appropriation and should be submitted on official voucher blanks."

It is recognized by the commission under present-day conditions that frequently larger fees are warranted and are allowed.

These fees do not, of course, govern the contractual relation between the physician and the claimant, and the physician and the employer, where the physician is called as the expert witness of either. But in those cases in which the physician appears as an expert witness for the injured employe, and seeks to have his fees paid directly out of the compensation award, it must be expected that the Industrial Commission will endeavor to protect the employe through permitting only what it considers to be a reasonable allowance for the expert. Each bill necessarily depends on the circumstances of the individual case, but the State Medical Society suggests to its members the practical necessity of submitting itemized statements substantiating the charges made by the expert witness.

With an itemized statement before it, the Industrial Commission is in a better position to judge of the work involved and of the reasonableness of the charges of the physician.

In the case of state employes who file compensation claims, the commission is explicit in its demands for itemized medical statements and for verification of the reasonableness of the charge:

> (Rule 18)
>
> "No claim for compensation or medical aid by an employe of the state will be allowed until the following reports and statements have been furnished to the Commission:
>
> "(2) A sworn statement by the injured employe to the effect that he was injured in the course of his employment and reciting the time and place of the injury, the reasons for its occurrence, and the nature of the injury, and also setting forth *in detail* the expenditures incurred for necessary medical, surgical and hospital treatment and medicines, (if these bills were paid by the injured, receipts must be attached) . . .
>
> * * *
>
> "(4) A sworn statement from the physician and the hospital itemizing the service rendered and the charges therefor . . .
>
> * * *
>
> "(5) A letter from the employing department, stating its recommendations upon . . . (b) the necessity for the medical, surgical and hospital treatment, (c) the reasonableness of the bills incurred for such treatment and for medicines; . . ."

Physicians should submit their reports promptly to the commission. Delay may mean the withholding of compensation to the injured employe and of professional fees to the physician.

Physicians must keep in mind the fact that where an appearance as an expert witness is made for a claimant and no award is granted, they must look directly to the employe for payment. Furthermore, where a physician treats an injured employe and such treatment has not been authorized by the employer, and the Industrial Commission finds no liability on the part of the employer, the physician must look directly to his patient for payment.

Estimating of Permanent Disability Under the Wisconsin Workmen's Compensation Act

With a general broadening of panels of physicians for the purpose of treating injured employes under the Wisconsin workmen's compensation act, it becomes desirable for physicians to have a clear understanding of the estimating of permanent disability under terms of the act. A study of the act as to benefit provisions, and particularly of the provisions of Sections 102.42, 102.43, 102.44, 102.52, 102.53, 102.55 and 102.565 is recommended. Copies of the compensation act in pamphlet form are available and will be forwarded by the Industrial Commission to any interested physician upon request.

Under the provisions of the workmen's compensation act, injuries may be divided into two types for the purpose of estimation of permanent disability, i. e., nonschedule and schedule injuries.

Nonschedule injuries. Nonschedule injuries are those to some portion of the body other than the legs, arms, ears or eyes, or their constituent parts. Generally speaking, nonschedule injuries are to the torso or to the head, exclusive of eye and ear injuries.

In the case of nonschedule injuries permanent disability is on the basis of a comparison between the nature of the *injury* and the nature of *an injury* causing permanent total disability. In the case of *Northern States Power Co. vs. Industrial Commission*, 252 Wis. 70, the court held that the fact that the injured suffered no actual loss of earnings did not deprive him for compensation for permanent disability based on permanent physical loss. The effect is to place so-called nonschedule types of injuries in essentially the same category as schedule injuries as to method of determination of permanent disability.

Schedule injuries. Schedule injuries are estimated upon a different basis, which bears no relation to wage loss. In these cases *the comparison is as between the injured limb and a normal limb*, having in mind all of the useful functions of the limb or organ. Schedule injuries apply to arms, legs, eyes and ears, as well as any constituent part of these members and organs. The estimate of disability takes no regard of any particular occupational use to which the member is to be put. The violin player who has lost a digit vital for the purpose of playing, and who may consequently lose much wage, receives exactly the same number of weeks' compensation as does the laborer who may be able to perform his work nearly as efficiently as before, even with the loss of a digit. The law fixes the value of each finger, thumb, toe, hand, arm, foot and leg at various joints. In the estimation of disability the doctor takes into consideration the percentage of loss of function which has resulted to the given unit as of the joint at which disability exists, or if disability is between joints, at the joint proximal to the point of disability. For example, if there is disability proximal to the wrist, but no disability above the elbow, the comparison is of the arm with a normal arm at the elbow, or, put conversely, with an arm which has been *amputated* at the elbow.

Because in every case of schedule injury, where there is a certain limitation of motion with no other element of disability involved, the functional disability is the same as in all identical cases, the estimate in such cases should be uniform. If the employe has lost his ability to raise his arm at the shoulder beyond the horizontal level and has no other disability, the estimate should manifestly be the same in his case as in all other cases where the limitation of motion is identical and where no other disability has resulted.

In case of schedule injuries the commission has found it possible to establish by custom or rule the related disability applicable to a given handicap. After many hearings with physicians, and in cooperation with the State Medical Society, the commission has adopted a schedule of related disabilities to serve as a guide in rating disabilities *short of amputations or total loss of all function.* In the example cited, where the loss of function is represented by a limitation of active elevation of the arm in all directions to 90 degrees, but otherwise normal, *the loss is interpreted at 20 per cent of the arm at the shoulder.* In all of the cases where landmarks have been adopted, the percentage of disability must vary as other conditions exist which constitute elements of functional loss. *If, for example, in addition to limitation of motion, there is disabling pain or weakness, a percentage must be added for these elements.* As the commission has adopted landmarks only for loss of certain specified functions representing disability, the physician must exercise his best judgment as to the percentage to be added for other items which may conduce to disability.

As a guide for the estimating of disabilities the commission has adopted the following table *representing per cent of loss of use as compared with amputations at involved joints.*

Shoulder

Total ankylosis at the shoulder with arm at side, scapula fixed	75%
Total ankylosis at the shoulder with arm at side, scapula free	55%
Limitation of active elevation to 45° but otherwise normal	35%
Limitation of active elevation in all directions to 90° but otherwise normal	20%
Limitation of active elevation to 135° but otherwise normal	5%

Elbow

Ankylosis of elbow joint at 45° less than full extension (radio-ulnar motion destroyed, hand 45° less than fully pronated)	60%
Limitation of motion of elbow joint (radio-ulnar motion unaffected)	
Remaining range, 90°–135°	20%
Remaining range, 135°–180°	35%
Ankylosis of radius and ulna, estimated at elbow joint (hand 45° less than fully pronated)	20%
Total ankylosis of arm at elbow at right angles	
a. With radio-ulnar motion intact	50%
b. With radio-ulnar motion destroyed (hand 45° less than fully pronated)	70%
Ankylosis of arm at elbow at 45° less than full extension with radio-ulnar motion intact	45%

Wrist

Ankylosis, straight position	25%

Fingers

Complete ankylosis

Thumb	Mid-position	Complete Extension
Distal joint only	25%	35%
Proximal joint only	15%	20%
Distal and proximal joints	35%	65%
Distal, proximal and carpometacarpal joints	85%	100%
Fingers		
Distal joint only	25%	35%
Middle joint only	75%	85%
Proximal joint only	40%	50%
Distal and middle joints	85%	100%
Distal, middle and proximal joints	100%	100%

Loss of Motion

Fingers	Loss of flexion	Loss of use	Loss of extension	Loss of use
Distal joint only	10%	= 1%	10%	= 2%
	20%	= 2%	20%	= 4%
	30%	= 3%	30%	= 6%
	40%	= 5%	40%	= 8%
	50%	= 10%	50%	= 15%
	60%	= 15%	60%	= 20%
	70%	= 20%	70%	= 30%
	80%	= 25%	80%	= 40%
			100%	= 60%

Loss of Motion

Fingers	Loss of flexion	Loss of use	Loss of extension	Loss of use
Middle joint only	10%	= 5%	10%	= 2½%
	20%	= 10%	20%	= 5%
	30%	= 15%	30%	= 10%
	40%	= 25%	40%	= 15%
	50%	= 40%	50%	= 30%
	60%	= 50%	60%	= 50%
	70%	= 60%	70%	= 70%
	80%	= 70%	80%	= 90%
			100%	= 100%
Proximal joint only	10%	= 5%	10%	= 2½%
	20%	= 10%	20%	= 5%
	30%	= 15%	30%	= 15%
	40%	= 20%	40%	= 20%
	50%	= 25%	50%	= 25%
	60%	= 30%	60%	= 40%
	70%	= 35%	70%	= 75%
	80%	= 40%	80%	= 85%
			90%	= 100%

(Where there is partial disability to two or more phalanges the estimate of the physician should take into consideration the greater cumulative effect because of such multiple disabilities. By analogy the allowances for complete ankylosis, where two or more joints are affected, may be used as a guide for comparison as to the greater allowance to be made because of the combined disabilities to two or more phalanges.)

Hip

Ankylosis in alignment for normal standing position	50%
Shortening of leg (no posterior or lateral angulation, age 50 or less)	
1 inch	7%
1½ inches	14%
2 inches	22%

(The percentages compare loss of the leg at the hip.)

Knee

Ankylosis at 170°	40%
Limitation of motion, remaining range 135°–180°	20%

Ankle

Ankylosis—favorable position 10 to 15 degrees equinus without loss of inversion and eversion	30%
Ankylosis—favorable position with loss of inversion and eversion	40%
Loss of inversion and eversion with full dorsi and plantar flexion remaining	15%

Report form. For use in reporting disabilities under the compensation act, the commission has adopted forms for use of physicians.

In order to enable the commission to pass upon disability, it becomes necessary that the physician's report contain as a minimum all of the information requested by this form. If in any case use is not made of the form, the physician should make certain that the requirements of the form are met. That will save returning the form to the physician with request for supplementary report.

In addition to the regular form, the commission has adopted another form of physician's report under the new provision of Sec. 102.17 (1) (as), effective June 10, 1943, which provides that the contents of verified medical and surgical reports by physicians and surgeons licensed in and practicing in Wisconsin presented by claimants for compensation shall constitute prima facie evidence as to the matter contained therein, subject to such rules and such limitations as the commission may prescribe. So, likewise, reports of physicians and surgeons, wherever licensed and practicing, to whom the claimant has been sent for examination and treatment by the employer or insurer, are available as evidence provided the doctor consents to subject himself to cross-examination.

The purpose of this provision is to make it unnecessary for the physician to appear personally in some cases, especially where the issue in dispute is of a simple nature and it is desirable to avoid expense to the applicant in arranging for the personal appearance of the physician at the time of hearing.

In addition to these forms the commission also makes use of a form for use in cases of loss of vision, which will be supplied to physicians upon their request, together with rules for determining loss of visual efficiency caused by industrial injury. In the case of partial deafness, no fixed rule has been adopted for determination. The physician should make use of recognized standards in reaching an estimate as to the percentage of loss of hearing which has resulted.

The law specifically provides that notwithstanding any other statutory provisions, any physician attending a workmen's compensation claimant may furnish to the employe, employer, workmen's compensation insurance carrier, or the Commission information and reports relative to a compensation claim. It provides further that a physician from outside Wisconsin may testify in compensation proceedings if he is licensed for the place of his residence or practice.

Forms are available upon request to the Industrial Commission.

Estimates of Disability

Obviously methods of estimating must be in accordance with the law, regardless of the personal feeling of the physician as to the correctness or justice of the law. In general, parties are probably in agreement as to the essential justice of these provisions. However, physicians may at times have some doubt in individual cases as to the equity of one or other provision, or may feel that the law is harsh or inadequate from the standpoint of either employer or employe. That feeling should never be allowed to influence the physician, either in treating or in estimating disability.

The physician who estimates disability should, under no circumstances, concern himself with the result in number of weeks or in dollars but should confine himself strictly to the medical field in estimating the disability on a functional basis. The physician should never suggest that a case should be settled on a certain basis but should confine himself to setting out his pertinent findings. It is the function of the employer and carrier, not that of the doctor, to propose the basis for settlement. The doctor's function is to report his factual findings with the probabilities and possibilities which may be involved, leaving to the employer or carrier the suggestion as to whether or not settlement should be made and upon what basis. It is clear that if the physician is influenced by the amount of compensation which may be paid to the injured, his estimate will not be on a valid basis. Neither should physicians attempt to compute the amount of compensation to become due. The law fixes the amount to be paid on the basis of disability which has resulted. This amount may be much greater or smaller than one or another physician might consider to be equitable. Computation of compensation based on estimates of disability is a function for the Industrial Commission. Attempts of physicians to compute very often result in erroneous figures and thus cause confusion and misunderstanding, both on the part of the physician and the injured person.

In the estimating of disabilities to members included within the schedule group, it should be remembered that 50 per cent loss of motion, or 50 per cent loss of strength, of itself *does not necessarily mean 50 per cent loss of function of the limb.* All functions of the limb must be considered, such as motion, freedom from pain, strength, coordination, quickness of action, endurance, sensation, etc. To each factor must be assigned by the physician the percentage which he considers represents the proportion of functional use of that factor as compared with all functions of a normal member, and to each factor must be applied the percentage of loss of the particular factor which has resulted. The total of the resulting percentages constitutes the percentage of disability to the member involved.

In those cases in which loss of motion is greater or less than that represented by the landmarks established by the commission, the physician must add or subtract such percentage as he believes will represent fairly the greater or smaller percentage of disability found to have resulted. In making his estimate the physician will be guided by the landmark laid down for the most nearly comparable disability for which a landmark has been established.

The cooperation of physicians is earnestly solicited by the commission in the making of prompt and complete reports to employers and insurance carriers, making it possible for them to pay compensation speedily and without interruption when due to employes. The commission feels that those physicians who, because of press of other business, or because of a lack of desire on their part to participate in the compensation program, find it impossible to do justice to the parties, or to make all necessary reports promptly, should not be included in panels for the purpose of treatment of

injured employes. Physicians have it within their power to hasten or delay the payment of compensation which is clearly due. Time is of the essence under the workmen's compensation act in the payment of compensation to those who usually are in urgent need because of their unexpected misfortune.

In this connection it should be pointed out that many reports have to be returned to physicians because of use of terminology which does not follow that set out in the statute. For example, the statute refers to the thumb, index, middle, ring and little fingers, and to disability at the distal, second and proximal joints. Some physicians refer to the first, second, third and fourth fingers, and some designate the thumb as the first finger. Also some physicians speak of the interphalangeal joints, and sometimes of the first, second and third joints, leaving confusion as to the point of measurement. If physicians will use the language of the statute, a good deal of confusion and necessity for supplementary reporting can be avoided.

As it is the commission's ultimate function to fix the percentage of disability, full reports covering all factors should be made, setting out in detail the elements which constitute disability, and stating as nearly as possible the weight and percentage of loss which has been ascribed to each. The physician should also set out his opinion as to the ultimate total percentage of disability which has resulted. That enables the commission to check the report with the commission's standards and to arrive at an intelligent and uniform conclusion.

From time to time physicians propose certain standards or schedules for the measurement of disability. The commission wishes to call attention to the fact that no standards or schedules not adopted by the commission have the approval of the commission. Only those standards adopted and published by the commission itself should be considered as authoritative or as representing the commission's thought as to percentages of disability based on certain functional losses. It is appreciated that other schedules may be studied as a matter of interest by physicians who will undoubtedly wish to arrive at an opinion based upon their own examination and analysis and by reference to the standards which the commission has authoritatively adopted.

It has not been the purpose of this resume to conduct an exhaustive analysis of the law in the many ways in which it may be related to the physician and his patient. Many questions will doubtless remain in the physician's mind.

But if the panel physician will appreciate the technical detail of much of the law and its administrative characteristics, he will find it easier to deal with the employer, the insurance carrier, and the patient. Both the office of the State Medical Society and the Industrial Commission will be happy to be of assistance in the medicolegal problems confronting the physician who treats patients entitled to, or claiming, benefits under the act. Inquiries may be directed either to the State Medical Society or to Mr. Harry A. Nelson, Director of Workmen's Compensation, State Capitol Annex, Madison 2, Wisconsin.

THE UNLICENSED PHYSICIAN

Problems arise when a physician comes to Wisconsin and enters association here with others engaged in medical practice before he has the chance to take the state board examination to be licensed for Wisconsin practice.

A physician so circumstanced, especially if he has been long in practice, may intend to refrain from practice until licensed, but not succeed. He may unintentionally and unwittingly, probably as a matter of habit, do many an act which might constitute, for him, illegal practice, or at least subject him to criticism, or worse.

The best advice, therefore, is for the physician to postpone contact with patients until his Wisconsin licensure is complete.

The next best advice is for him to be circumspect. Let him issue no prescriptions over his own signature. Let him see patients only in consultation with his associates who are already licensed. Let him act the part not of a physician, but at most the part of an apprentice or a physician's deputy.

Agreement on Panel Practice

PRIOR to 1939, the workmen's compensation act provided that employers of three or more employes could not be required to maintain a panel of more than five physicians from among whom the injured employe might make his choice of attendant. At the suggestion of the insurance companies selling workmen's compensation insurance in Wisconsin, the State Medical Society of Wisconsin entered into a joint agreement with them to enlarge the panels through the voluntary cooperation of employers and the insurance companies in an effort to give the workmen of this state an opportunity to secure virtual free choice of physician. Through this agreement, any member of the State Medical Society of Wisconsin who indicates his willingness to serve injured employes may have his name included in the panel whch is certified to the insurance company. This agreement makes it possible for approximately 80 per cent of the workmen in Wisconsin to have a wide choice of physician.

The attention of members is specifically called to the provision under the application for placement on panels that the member agrees to have consultation when so requested by the insurance carrier. **The member also agrees to communicate with the insurance carrier in regard to the consultant in order that the consultant might be mutually agreed upon.** It is recognized that exceptions will occur to this portion of the agreement, but the exceptions should occur only in the event of an emergency.

The agreement on panel practice in Wisconsin as adopted by the Council of the Society and the insurance company association is as follows:

Agreement on Panel Practice in Wisconsin

The workmen's compensation law of Wisconsin requires "the employer to maintain a reasonable number of competent and impartial physicians, ready to undertake the treatment of the employe, and to permit the employe to make choice of his attendant from among them." What is "a reasonable number" is for the commission to determine, taking account of the community medical resources and needs. In many communities the common interests of the employer, the injured employe and of the medical profession will be more equitably served by liberalizing the minimum statutory requirement. In order to provide a larger medical panel from which the injured employe may select his attending physician, representatives of both the stock and mutual insurance companies writing compensation coverage in the State of Wisconsin, and representatives of the State Medical Society of Wisconsin, established the following principles:

1. The State Medical Society will prepare, and make available to insurance carriers, panels listing the names of all those physicians in each component county society desiring to accept employes eligible for treatment under the workmen's compensation act. This list and the panels will be kept as accurate as possible, but need not be revised more often than January 15 and July 15 of each year. If any panel distributed by an insurance carrier includes the names of any physicians not members of the State Medical Society, nothing thereon shall indicate that it has been approved by said Society.

2. A State Conference Committee of four, two representing insurance carriers and two representing the State Medical Society will be established, whose function it will be to coordinate the obligations of the insurance carriers with the facilities of the medical profession to provide proper benefits to injured employes. Specifically such committee shall have the duties of:

a. Mediating, if possible, those cases where the insurance companies complain that the attending physician has neglected or refused to furnish the reports reasonably necessary.

b. Mediating, if possible, those cases where it is complained that the insurance carriers have unreasonably interfered with what is properly in the discretion or control of the attending physician.

c. Reviewing any situation in which it is claimed that there has been a violation of medical ethics and, in its judgment, referring any facts relative thereto to the Board of Censors of the County Medical Society.

d. Mediating, if possible, differences that may arise between the attending physician and the insurance carrier relative to remuneration.

e. Hearing any complaints relative to the competency of those serving on such panels and removing their names therefrom if, upon investigation, it is found that such complaints are justified.

In the event of complaints from either insurance carriers or physicians the State Conference Committee may designate a special local committee to investigate and report to the State Conference Committee with recommendations as to the action to be taken. Both the State Conference Committee and the special local committees will attempt to mediate only those cases wherein the physician involved is on the listing provided by the State Medical Society.

3. It is understood that this is a trial plan and is necessarily limited to the State of Wisconsin. Any modifications of this general statement of principles to be effective must be approved by the State Conference Committee.

University Hospitals

IN ORDER to properly characterize and at the same time to avoid confusion, the single term, University Hospitals, is presently being used with the following designated units included under this grouping.

Student Infirmary
Mary Cornelia Bradley Memorial Hospital
State of Wisconsin General Hospital
Wisconsin Orthopedic Hospital for Children
Cancer Research Hospital

According to the provisions of chapter 142 and section 36.31, Wis. Stats., the State of Wisconsin General Hospital, located in Madison, was established for two primary purposes: (1) to furnish facilities for teaching and the advancement of medical knowledge; and (2) to furnish specialized facilities for the care and hospitalization of patients lacking such facilities within their own communities.

142.01 **Public patients.** (1) A person having a legal settlement in any county in this state who is crippled or ailing and whose condition can probably be remedied or advantageously treated, if he or the person liable for his support is financially unable to provide proper treatment, may be treated at the Wisconsin general hospital or the Wisconsin orthopedic hospital for children at Madison or in such other hospital or rehabilitation camp as the county judge shall direct, except that when the person to be treated, or his guardian if he be under guardianship, shall select that such treatment be at the said Wisconsin general hospital or the said Wisconsin orthopedic hospital or rehabilitation camp, the hospital or rehabilitation camp of his selection shall be the place of treatment; provided that the right of such selection shall not exist in counties having a population of five hundred thousand or more . . .

142.02 **Application.** When the case of such person shall come to the notice of the sheriff, county supervisor, town clerk, health officer, health nurse, poor commissioner, policeman, physician or surgeon, or any public official, he shall and any teacher, priest or minister may, file with the county judge of the county wherein such afflicted person has a legal settlement an application for such treatment at such hospital.

The judge then appoints a physician to investigate the physical condition of the patient. At the same time the judge makes an investigation as to the propriety of such a commitment. The supervisor of the town, village or ward of residence of the person is required to furnish the court, upon request, with all material information within his knowledge in order that the judge may intelligently decide the case. If the judge is satisfied that the patient or the person liable for his support is financially unable to provide proper treatment and upon recommendation of the physician that the patient is a proper person for hospitalization at the State of Wisconsin General Hospital, the judge shall then issue an order approving such hospitalization, in which instance the cost is borne equally by state and county, provided that the county has not exceeded its quota for that year.

Unless the case is an emergency, the hospital desires the court order certifying the patient to the institution prior to the arrival of the patient. This allows the hospital to delay admission in certain cases where the services are already overcrowded.

Patients are also admitted to the hospital upon receipt of a letter from the family physician stating that the patient can pay $18.50 a day, in advance, for hospitalization, but that a professional fee or extras in addition would be a severe hardship. A few private cases are also admitted, but the hospital is not primarily interested in this type of work. Address all communications to the office of the Superintendent, 1300 University Avenue, Madison, Wisconsin, or telephone Alpine 6–6811.

Classification of patients admitted to the hospital is given below:

1. *County-state patient:* Hospitalization is authorized by the county judge of the county in which patient resides. Hospitalization costs are paid equally, half by the county and half by the state until that county's quota for that year is exhausted in which case the county bears the full cost.

2. *Special rate patient* (formerly called the "clinic case"): This type of patient comes to the hospital on his physician's recommendation that he be accepted on $18.50 per day basis. A financial statement of the patient is taken on admission, and if it is felt that his status justifies an $18.50 per day charge, he is admitted on that basis. He is thereby entitled to every service except transfusions and special nursing.

3. *Private patient:* This type of patient is handled the same as would be the case in any other hospital *except* that he is accepted only on reference or recommendation of the physician in the home community.

4. *War Veterans:* Any honorably discharged veteran of any war (Korean service not included) of the United States, who has been a resident of the state for not less than five years preceding his admission, may be admitted to the hospital and obtain all care including professional service at the established per diem rate ($5.90). War veterans are required to present their honorable discharge papers and sign a statement declaring residency for the last five years preceding admission to the hospital. War veterans may be admitted as private patients of individual staff members if properly referred, in which case hospital rate is as above, but professional fee applies.

Patients are also seen in the Outpatient Department of the Hospitals upon reference from the family physician or official agency. Registration fees for most outpatient clinics follow:

Public Patient	$ 1.00
Special Rate Patient	5.00
Private Patient	5.00

These fees are in addition to hospital charges for x-rays, special drugs, etc., and they do *not* include professional fees if they are applicable.

A similar schedule of fees for the Tumor Clinic has been established.

For the Easter Seal Cerebral Palsy Center, the fees are as follows:

Public Patient	$ 1.00
Special Rate Patient	7.50
Private Patient	15.00

No patient is accepted at Wisconsin General Hospital unless referred or recommended by the patient's physician, except in case of emergency or accident where delay may cause serious complications.

Units of University Hospitals

State of Wisconsin General Hospital: Admissions per above; general hospital service plus teaching privileges in connection with the University.

Wisconsin Orthopedic Hospital: Orthopedic and plastic surgery patients only. All patients admitted through the regular admitting channels of the Wisconsin General Hospital and with the approval of the Crippled Children's Division.

The Mary Cornelia Bradley Memorial Hospital for Children: This is the Pediatric Department of the State of Wisconsin General Hospital and is not a separate unit.

University of Wisconsin Student Infirmary: Student health center and hospital.

Cancer Research Hospital: An integral part of the additions to the State of Wisconsin General Hospital, dedicated by the National Institutes of Health in January 1952.

Treatment May Be at Home or in Local Institution

Under the Wisconsin General Hospital Law (sections 142.01 and 142.04) a person having a legal settlement in any county, who is crippled or ailing and whose condition can probably be remedied or treated advantageously, and for whom treatment is financially impossible, may be confined, as the situation warrants, in the Wisconsin General Hospital, in the Wisconsin Orthopedic Hospital, in a local institution or at home.

Conditions Necessary to Local Treatment

Where treatment is to be given at home or in a local institution, the court must find that such treatment will be adequate and at the same or less expense to the county. But it must be kept in mind that the law is beneficent, and must be construed to give effect to its purpose. And in the consideration of "expense," the county judge may take into account the costs necessary to remove a patient to Madison, for transportation expense, and those of an attendant, both to and from the institution, are not items of joint state and county expense.

The County Quota

Under the provisions of the law, state aid ceases when the total county patients committed from any one county exceeds a ratio of more than two persons per thousand of population or major fraction thereof, although there is no limit if there is no hospital in the county concerned nor as to patients certified to the Wisconsin Orthopedic Hospital. The decision whether there is a hospital in the county is for the secretary of state at the time he certifies to the county its share of the costs. 30 Atty. Gen. 98. If the county exceeds its quota, then the county must pay the entire cost of hospitalization if the patient is to be confined in Madison. If the patient is confined at home under the provisions of the law, no expense of hospitalization is involved at all. The only expense to the county would be that of medical care and nursing.

Physicians' Fees

In proceedings under the Wisconsin General Hospital Law, two entirely separate and distinct fees are permitted physicians.

By provisions of section 142.03 (2) the county judge, if satisfied that a patient presents a proper situation, "shall appoint a physician personally to examine the person." By statute, the physician is directed to make a verified report in writing giving certain required information, and shall "be paid by the county $5.00 and actual and necessary expenses." Since no method is provided for the payment of the physician, he must proceed through legal channels for the collection of the $5.00 fee allowed. Following the provisions of section 59.77 (1), dealing with claims against the county, the physician must make a statement of his claim in writing upon county voucher forms setting forth its nature and the facts upon which it is founded. If the claim includes mileage, the statement should specify the days and places, so as to show between what points, and when, and the purpose for which the travel charges were made. Since the fee is statutory, the time expended in the performance of service need not be stated. But the statement must be verified by affidavit and filed with the county clerk, whose duty it is, under the provisions of section 59.79 to transmit the same to the county board.

The expense of treatment of such patients, in local institutions or at home, shall be paid by the county treasurer, upon the certificate of the county judge who shall be satisfied as to the correctness and reasonableness thereof. The claim of the physician rendering the treatment need not be passed upon by the county board, but only by the county judge. See sections 142.04 and 142.08 (5). See also 21 Atty. Gen. 240 and 22 Atty. Gen. 408.

State Board of Health Communicable Disease Rules

AN OVER-ALL VIEW

THE official Board of Health has the responsibility for determining the policies to be followed by the department and for the approval of programs to be developed or in operation. Its seven members are appointed by the governor with the consent of the senate for seven year terms. The Board elects a secretary, who is also the State Health Officer.

Powers of the Board include that of making and enforcing rules and regulations, holding hearings, and issuing orders on subjects under its jurisdiction as established by Statute.

The work of the Board and of the department is supplemented by local boards of health and health officers in all towns, villages, and cities of Wisconsin. The staffs of the eight district health offices keep in touch with the local boards and officers and assist them in any problem that may arise.

Reportable Communicable Diseases

Summary of Rules

Disease	Isolation Patient	Restriction Contact	Placard
Actinomycosis	None if under medical care	None	None
Amebic dysentery	Food handling restricted	Food handling restricted	None
Anthrax	Until lesions healed	None	None
Bacillary dysentery	Food handling restricted	Food handling restricted	None
Brucellosis	None	None	None
Chickenpox	7 days from onset	None	None
Cholera	14 days or negative stools	5 days or negative stools; see also H 49.10	Yes
Diarrhea, newborn	Special; see rule	See rule	None
Diphtheria	10 days and negative cultures	5 days and negative cultures; see also H 49.10	Yes
Encephalitis	7 days from onset	None	None
German measles	7 days from onset	None	None
Hemorrhagic jaundice	None	None	None
Hepatitis, infectious	7 days from onset	None	None
Histoplasmosis	None	None	None
Leprosy	Yes; see rule	None	None
Malaria	Until blood negative for parasites	None	None
Measles	7 days from start rash	Susceptibles: 7 days beginning 2nd week exposure	None
Meningitis, meningococcal	See rule	None	None
Mumps	Minimum 7 days	None	None
Ophthalmia neonatorum	None if under medical care	None	None
Paratyphoid and carrier	7 days after symptoms and 2 negative cultures	Food handling restricted; see also H 49.10	None
Plague	Minimum 14 days	In pneumonic form, 7 days from last exposure; see also H 49.10	Yes
Poliomyelitis	At least 7 days from onset	Household contacts under 16–18 one week; see rule	None
Psittacosis	During acute stage of disease	None	None
Rabies	None if under medical care	None	None
Rheumatic fever	None	None	None
Salmonellosis (other than typhoid and paratyphoid)	None	Food handling restricted; see also H 49.10	None
Smallpox	Until disappearance of crusts and scabs	18 days or successful vaccination within 3 days of exposure; see also H 49.10	Yes
Streptococcal Infections, Respiratory (including Scarlet Fever, Streptococcal Sore Throat, and "Septic Sore Throat")	Not less than 7 days; see rule	None except by rule of local board of health; see also H 49.10	None
Tetanus	None	None	None
Tinea capitas	Limited; see rule	None	None
Trachoma	None if under medical care	None	None
Trichinosis	None	None	None
Tuberculosis	Special; see rule	None	None
Tularemia	None	None	None
Typhoid fever and carrier	7 days after symptoms and 2 negative cultures	Food handling restricted; see also H 49.10	None
Typhus	During febrile period; delousing	Delousing	None
Venereal disease	None if under medical care	Examination	None
Whooping cough	28 days from onset	Limited: see rule	None
Yellow fever	7 days	None	None

Part I. Rules and Regulations of the State Board of Health in the Control of Communicable Diseases

H 45.01 Reporting

All communicable diseases which are designated as reportable under these rules shall be reported by all physicians and other persons having knowledge of such diseases to the local health officer and by the local health officer to the state board of health unless otherwise specifically provided.

H 45.02 Definitions

(1) *Case.* A person whose body has been invaded by an infectious agent, with the result that symptoms have occurred.

(2) *Carrier.* A person who harbors a specific infectious agent without demonstrating symptoms or signs of the disease.

(3) *Contact.* A person who has been intimately in contact with an infected person such as the daily contact of a patient with his parents, his brothers and sisters, other occupants of the home, and the like.

(4) *Isolation.* By isolation is meant the separation of cases or carriers from other persons in such places and under such conditions as will prevent the direct or indirect conveyance of the infectious agent to susceptible persons.

(5) *Quarantine.* By quarantine is meant the limitation of freedom of movement or isolation of contacts who have been exposed to a communicable disease, for a period of time equal to the longest usual incubation period of the disease to which they have been exposed.

(6) *Disinfection.* Disinfection denotes the destruction of infectious agents by chemical or physical means. In general, two types of disinfection are employed:

(a) *Concurrent.* Disinfection carried on continuously during the illness of the patient, such as destruction by use of chemical or physical means of discharges of the patient and cleaning of any infectious material which has come into contact with the patient or may have been soiled by him.

(b) *Terminal.* The elimination of the infectious agent from personal clothing, belongings, and the immediate physical environment of the patient.

H 45.03 Enforcement

It shall be the duty of the health officer of every local board of health in this state to enforce the rules of the state board of health covering communicable diseases or a suspected case of communicable disease whenever a case is reported or becomes known to him within his jurisdiction.

H 45.04 Communicable Diseases

The diseases listed in rules H 45.05 through 47.12 are declared to be communicable diseases and the control measures for each specific disease shall be as herein provided. All reasonably suspected cases of communicable diseases shall be regarded as actual cases until proved otherwise and all rules and regulations applicable to actual cases shall be applied to them.

H 45.05 Actinomycosis

(1) Patient

(a) Placard—None

(b) Restrictions—Isolation: None, provided the patient is under medical supervision.

(c) Reporting required

(2) Contacts—No restrictions

(3) Environment

(a) Concurrent disinfection of discharges from lesions and articles soiled therewith.

(b) Terminal disinfection by thorough cleaning

H 45.06 Amebic Dysentery

(1) Patient

(a) Placard—None

(b) Restrictions—Isolation: None. No person having amebic dysentery, or who is a carrier of amebic dysentery, shall handle, prepare, or serve food for public consumption until completion of treatment and three negative stool tests, taken not less than one day apart, are obtained.

(c) Reporting—All cases and carriers of amebic dysentery shall be reported to the local health officer. The occupation of such persons shall be forwarded in the report.

(2) Contacts—Restrictions: Quarantine—None. Contacts within the home are prohibited from handling or preparing food for public consumption until two negative stool tests, on consecutive days, are obtained.

(3) Environment

(a) Where the premises occupied by the patient or carrier are unsewered, the health officer shall cause all vaults and cesspools to be sufficiently disinfected and kept fly-proof and vermin-proof by screening or other effective arrangements.

(b) Concurrent disinfection—Sanitary disposal of the bowel discharges is required.

H 45.07 Anthrax

(1) Patient

(a) Placard—None

(b) Restrictions—Isolation until the lesions have healed

(c) Reporting required

(2) Contacts—No restrictions

(3) Environment

(a) Concurrent disinfection of the discharges from lesions and articles soiled therewith.

(b) Terminal disinfection—Thorough cleaning

H 45.08 Bacillary Dysentery

(1) Patient

(a) Placard—None

(b) Restrictions—Isolation: None. No person having bacillary dysentery, or who is a carrier of bacillary dysentery shall handle, prepare, or serve food for public consumption which is not subsequently to be cooked, until completion of treatment and two negative stool tests taken not less than one day apart.

(c) Reporting—All cases and carriers of bacillary dysentery shall be reported to the local health officer. The occupation of such persons shall be forwarded in the report.

(2) Contacts—Restrictions: Quarantine—None. Contacts within the home are prohibited from handling or preparing food for public consumption until two negative stools are obtained.

(3) Environment

(a) Where the premises occupied by the patient or carrier are unsewered, the health officer shall cause all vaults and cesspools to be sufficiently disinfected and kept fly-proof and vermin-proof by screening or other effective arrangements.

(b) Concurrent disinfection—Sanitary disposal of the bowel discharges is required.

H 45.09 Brucellosis

(1) Patient

(a) Placard—None

(b) Restrictions—Isolation: None

(c) Reporting required

(2) Contacts—No restrictions

(3) Environment

(a) Concurrent disinfection—None

(b) Terminal disinfection—None

H 45.10 Chickenpox

(1) Patient

(a) Placard—None

(b) Restrictions—The patient is to be isolated for seven days at home from date of onset.

(c) Reporting—All cases are to be reported to the local health officer. The diagnoses of all cases of chickenpox occurring in persons over 15 years of age are to be verified by a physician. Where a physician is not employed by the family, the local board of health is required to furnish a physician for the verification of such diagnosis.

(2) Contacts—Restrictions: Quarantine—None. Well children in the family may attend school but are to be observed by the teacher and excluded if they show any evidence of illness.

(3) Environment—There is to be concurrent disinfection of all articles soiled by discharges from the nose and throat as well as from the lesions.

H 45.11 Cholera

(1) Patient

(a) Placard required

(b) Restrictions—The patient is to be isolated in a hospital or a well-screened room for 14 days or until the stool is found to be free from cholera vibrio on three consecutive days.

(c) Reporting—All cases are to be reported to the local health officer within 24 hours.

(2) Contacts—Restrictions: All contacts are to be quarantined for a period of five days from the date of last exposure and until two negative, consecutive cultures are obtained.

(3) Environment

(a) Concurrent disinfection—There is to be prompt and thorough disinfection of the stools and vomitus. Articles used by and in connection with the patient are to be disinfected. Food left by the patient is to be burned.

(b) Terminal disinfection—The room in which a patient was isolated is to be thoroughly cleaned.

H 45.12 Diarrhea of the Newborn

(1) Patient

(a) Placard—None

(b) Restrictions—Immediate removal of affected baby from nursery to isolation ward. Closure of contaminated nursery to new admissions and suspension of maternity service.

(c) Reporting—The occurrence of any case of diarrhea of the newborn is to be immediately reported to the local health officer in those communities which employ a full-time health officer. In those communities where a full-time health officer is not employed, the occurrence of diarrhea of the newborn is to be reported directly to the Wisconsin state board of health.

(2) Contacts—Restrictions: All exposed babies in the nursery are to be cared for by separate medical and nursing personnel.

(3) Environment

(a) All articles within the nursery are to be disinfected as thoroughly as practical.

(b) Terminal disinfection—Thorough cleansing of the premises.

H 45.13 Diphtheria

(1) Patient

(a) Placarding required

(b) Restrictions—The patient is to be isolated for at least 10 days and until two consecutive, negative nose and throat cultures, taken not less than 24 hours apart, are obtained.

(c) Reporting—All cases and carriers shall be reported to the local health officer.

(2) Contacts—Restrictions: All intimate contacts are to be quarantined for at least five days and until two consecutive, negative nose and throat cultures are obtained. Children in the family with the patient may not return to school until all persons within the affected household have been shown to no longer carry the etiologic agent.

(3) Environment

(a) All carriers of diphtheria bacilli are to be handled as cases unless laboratory examination demonstrates that the organisms are not virulent.

(b) All articles which have been in contact with the patient and all articles soiled by discharges of the patient are to be concurrently disinfected.

H 45.14 Encephalitis

(1) Patient
  (a) Placard—None
  (b) Restrictions—The patient is to be isolated in a well-screened room for an interval of seven days from the onset of the disease.
  (c) Reporting—All cases are to be reported to the local health officer within 24 hours.
(2) Contacts—Restrictions: Quarantine—None.
(3) Environment—Concurrent disinfection: None except for the purpose of destroying mosquitoes in the house occupied by the patient and in the nearest neighboring dwellings.

H 45.15 Food Poisonings

All instances of food poisoning or suspected food poisoning in which there is reason to believe that the purchase or consumption of the incriminated food occurred at a store or eating place accessible to the general public shall be reported.

H 45.16 German Measles

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation at home for seven days from onset.
  (c) Reporting—All cases are to be reported to the local health officer.
(2) Contacts
  (a) Restrictions—Quarantine: None
  (b) Other children in the family may attend school but are to be observed by the teacher and excluded if they show evidence of illness.

H 45.17 Hemorrhagic Jaundice

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation: None
  (c) Reporting required
(2) Contacts—No restrictions
(3) Environment
  (a) Concurrent disinfection—Urine and other discharges of patient.
  (b) Terminal disinfection—None

H 45.18 Hepatitis, Infectious

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation during the first week of illness
  (c) Reporting required
(2) Contacts—No restrictions
(3) Environment
  (a) Concurrent disinfection—Discharges of nose, throat, and bowels of the patient.
  (b) Terminal disinfection—None

H 45.19 Histoplasmosis

(1) Patient
  (a) Placard—None
  (b) Restrictions—None
  (c) Reporting required
(2) Contacts—No restrictions
(3) Environment—No requirements

H 45.20 Leprosy

(1) Patient
  (a) Placard—None
  (b) Restrictions—The patient is to be isolated at home until transferred to a national leprosarium.
  (c) Reporting required
(2) Contacts—No restrictions
(3) Environment
  (a) Concurrent disinfection—Of all discharges and articles soiled with discharges from the patient.
  (b) Terminal disinfection—Cleansing of premises after removal of patient.

H 45.21 Malaria

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation in a well-screened room until blood is negative for parasites.
  (c) Reporting required
(2) Contacts—Restrictions: Quarantine—None
(3) Environment—Concurrent disinfection: None except for the purpose of destroying mosquitoes in the house occupied by the patient and in the nearest neighboring dwellings.

H 45.22 Measles

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation at home for seven days upon appearance of rash.
  (c) Reporting required
(2) Contacts—Restrictions: Susceptible contacts in the home are to be restricted to the premises beginning the second week after exposure for a period of seven days.
(3) Environment—Concurrent disinfection: All articles soiled with secretions of the nose and throat are to be concurrently disinfected.

H 45.23 Meningitis, Meningococcal

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation until 48 hours after the institution of treatment with a sulfonamide or penicillin. In the absence of such treatment the patient is to be isolated for two weeks.
  (c) Reporting—The occurrence of meningococcic meningitis is to be reported to the local health officer within 24 hours.
(2) Contacts—Restrictions: Quarantine—None
(3) Environment—There is to be concurrent disinfection of discharges from the nose and throat or articles soiled with these discharges.

H 45.24 Mumps

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation of patient for at least one week or until disappearance of swelling.
  (c) Reporting required

(2) Contacts — Restrictions: Quarantine — None. Other children in the family may attend school but are to be observed by the teacher and excluded if they show any evidence of illness.

H 45.25 Ophthalmia Neonatorum

(1) Patient
  (a) Placard—None
  (b) Restrictions—None provided the patient is under adequate medical supervision.
  (c) Reporting—None except as provided in *Sec. 146.01 (2)* which requires reporting to the local health officer in cases not attended by a physician or midwife.

(2) Contacts—No restrictions

(3) Environment
  (a) Concurrent disinfection of conjunctival discharges and soiled articles.
  (b) Terminal disinfection—Thorough cleaning

(4) Prevention—The attending physician or midwife is required to place two drops of a one per cent solution of silver nitrate in each eye of a newborn child immediately after delivery. Failure to observe this requirement is punishable by a fine of not more than one hundred dollars. *(Sec. 146.01)*

H 45.26—H 45.32 PARATYPHOID FEVER

H 45.26 Paratyphoid Fever—Patient

(1) Placard—Not required

(2) Restrictions—Isolation for at least one week beyond the time that all symptoms subside and until two negative, consecutive specimens of feces are obtained at least five days apart.

(3) Reporting required

H 45.27 Paratyphoid Fever—Contacts

(1) Quarantine—None

(2) Family contacts are not to be permitted to handle food during the period of contact nor before two negative, consecutive stool and urine cultures are obtained.

H 45.28 Paratyphoid Fever Cases—Environment

(1) Concurrent disinfection of all bowel and urinary discharges and articles soiled with them.

(2) Terminal disinfection through a thorough cleaning of the premises

(3) Suppression of flies

H 45.29 Paratyphoid Carrier—Definition

A person shall be considered a paratyphoid carrier, capable of transmitting the disease to susceptible persons if:

(1) During or following his convalescence from the disease his feces and/or urine have not been proved free from paratyphoid bacilli by examination in a laboratory approved for release cultures (temporary carrier).

(2) He has not suffered from paratyphoid fever within one year, but paratyphoid bacilli are found in his urine or feces when examined in a laboratory approved for release cultures (chronic carrier).

(3) Epidemiological evidence points to such person as the source of one or more cases of the disease and from whom for any reason specimens of urine or feces have not or cannot be obtained for examination in a laboratory approved for release cultures.

H 45.30 Paratyphoid Carriers—Rules Governing

(1) The urine and feces of a paratyphoid carrier shall be disposed of in such a manner as not to endanger any public or private water supply or be accessible to insects or rodents.

(2) If food products, which are to be consumed raw by others, are produced on premises occupied by a paratyphoid carrier, the water supply shall be proved free from contamination.

(3) No paratyphoid carrier shall engage in the handling or preparation of any food or drink to be consumed on the premises by others than members of his family with whom he resides or to be consumed off the premises prior to cooking. This restriction shall apply to visitors, roomers, lodgers, and employees.

(4) No paratyphoid carrier shall engage in the occupation of nurse, nursemaid, domestic servant, cook, waiter, dishwasher, or public eating-house employee.

(5) No paratyphoid carrier shall engage in any occupation involving the handling of milk, cream, or milk products, or the utensils used in the production thereof. No paratyphoid carrier shall reside on premises where milk is produced for distribution off the premises unless the carrier, or if he be a minor, his parent or legal guardian, and the owner of the milk-producing cows agree in writing:
  (a) That the carrier will not engage in milking or handling of milk, cream, or dairy utensils, nor enter the house or barn where milk is produced or handled.
  (b) That no milk or cream is subsequently to be sold nor any utensils used in the production of milk or cream shall be brought into the house occupied by the carrier.
  (c) That all persons residing or employed on the premises who are susceptible to paratyphoid shall be vaccinated against paratyphoid fever at least every three years. Where the provisions of such agreement are not followed, distribution and sale of milk from such premises are prohibited.

(6) No paratyphoid carrier shall reside in or be employed in a boarding house or camp.

(7) No carrier shall change his place of residence without notifying the local health officer of his intended residence, who shall immediately inform the state board of health of the facts.
(8) In any situation not covered by the above rules and in which a paratyphoid carrier endangers the public health, the carrier shall observe such recommendations as the state board of health may make for the particular case.

H 45.31 Paratyphoid Carriers—Release

Following isolation for paratyphoid fever a person adjudged a temporary carrier may be released from restrictions only after two successive specimens of feces, passed at an interval of not less than five days, shall have been examined in a laboratory approved for release cultures and found free from paratyphoid bacilli; except that if the person is to handle milk, dairy, or food products the number of negative cultures shall be four, two of which shall have been examined in a laboratory approved by the state board of health for release cultures.

H 45.32 Chronic Paratyphoid Carriers — Conditions for Release

(1) Each of at least 18 successive specimens of feces taken at intervals of 30 days under conditions that do not permit of substitution have been examined in a laboratory approved for release cultures by the state board of health and found to contain no paratyphoid bacilli.
(2) Where an individual has been found to be excreting the organisms through the urinary tract, then the requirements for release of carrier status under paragraphs H 45.31 and H 45.32 (1) shall apply for urine specimens as well.

H 45.33 Plague

(1) Patient
  (a) Placard—Required
  (b) Restrictions—Isolation of patient in a hospital or well-screened room which is free from vermin for a period of at least two weeks.
  (c) Reporting required
(2) Contacts—Restrictions: Quarantine of persons exposed to the pneumonic form of the disease for a period of one week from the date of last exposure.
(3) Environment
  (a) Concurrent disinfection of sputum and soiled articles
  (b) Extermination of rats and vermin from the premises

H 45.34 Poliomyelitis

(1) Patient
  (a) Placard—Not required
  (b) Restrictions—The patient is to be isolated for a period of at least one week from the onset of symptoms (or for the duration of fever if longer).
  (c) Reporting required
(2) Contacts—Restrictions
  (a) Household contacts under 18 years of age are to be restricted to their homes, for a period of one week from the date of the onset of acute symptoms in the first household case.
  (b) Household contacts who are 16–18 years of age (employed full-time) and who do not come into close contact with children in the course of their occupation shall comply with adult restrictions only.
  (c) Adult household contacts: Teachers and others who come in close contact with children must cease their occupation for an interval of one week from the date of onset of the first household case.
(3) Environment—Concurrent disinfection: All discharges from the nose and throat and bowel are to be concurrently disinfected.

H 45.35 Psittacosis

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation during the febrile and acute clinical stage of the disease.
  (c) Reporting required
(2) Contacts—No restrictions
(3) Environment
  (a) Concurrent disinfection of all discharges
  (b) Terminal disinfection—Destruction of infected birds

H 45.36 Rabies

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation: None if the patient is under medical supervision and the immediate attendants are warned of possibility of inoculation by human virus.
  (c) Reporting required
(2) Contacts—No restrictions
(3) Environment
  (a) Concurrent disinfection of saliva of patient and articles soiled therewith.
  (b) Terminal disinfection—None

H 45.37 Rheumatic Fever (Active)

(1) Patient
  (a) Placard—None
  (b) Restrictions—None
  (c) Reporting required
(2) Contacts—No restrictions
(3) Environment—No requirements

H 45.38 Salmonellosis (Other Than Typhoid Fever and Paratyphoid Fever)

(1) Patient
  (a) Placard—Not required
  (b) Restrictions
    1. Isolation—Not required
    2. All cases will be considered convalescent carriers after clinical recovery unless

they have two successive negative fecal cultures, taken not less than 24 hours apart, and performed by a laboratory approved for such purposes by the state board of health. After six months they shall be considered chronic carriers.

(c) Reporting required

(2) Carriers

(a) All carriers (convalescent and well carriers) are restricted from engaging in food handling activity other than in the preparation of food for their own immediate families.

(b) No carrier shall be employed in an occupation requiring close personal contact with other individuals, such as caring for disabled or sick individuals or infants in hospitals and nurseries.

(c) Chronic carriers may be released after three consecutive stool cultures taken not less than 24 hours apart have been found to be negative for Salmonella organisms when cultured by a laboratory approved for such purposes by the state board of health.

H 45.39 Smallpox

(1) Patient

(a) Placard required

(b) Restrictions—Isolate until the disappearance of all scabs and crusts.

(c) Reporting required

(2) Contacts—Restrictions: Quarantine for 18 days from date of last exposure unless a successful vaccination has been obtained within three days of exposure.

(3) Environment

(a) Concurrent disinfection—No article is to leave the immediate surroundings of the patient without boiling or equally effective disinfection.

(b) Terminal disinfection — Thorough cleaning of the premises

H 45.40 Streptococcal Infections, Respiratory (Including Scarlet Fever, Streptococcal Sore Throat, and "Septic Sore Throat")

(1) Patient

(a) Placard—None

(b) Restrictions—The patient shall be isolated until the complete disappearance of inflammation and discharges from the nose and throat, ears, or suppurating glands; and in any case for not less than seven days from onset.

(c) Reporting required

(2) Contacts

(a) Household contacts — It is recommended that household contacts be kept under medical observation for the development of streptococcal disease during the incubation period. Restriction of contacts is not required, except at the discretion of the local board of health, and as specified in **H 49.10.**

(b) Other contacts—No restrictions are required

(3) Environment

(a) Concurrent disinfection—All articles which have been soiled by purulent discharges and all articles which have been in contact with the patient are to be concurrently disinfected.

(b) Terminal disinfection—A thorough cleaning of contaminated objects, scrubbing of floors, and sunning of blankets to prevent dissemination of infected particles.

H 45.41 Streptococcal Diseases Other Than Respiratory Erysipelas and Puerperal Infection

(1) Patient

(a) Placard—None

(b) Restrictions—The patient is to be isolated for the duration of the acute stage of the disease.

(c) Reporting—None

(2) Contacts—Restrictions: None

(3) Environment

(a) Concurrent disinfection—Careful disposal of dressings and discharges from the patient.

(b) Terminal disinfection—General thorough cleaning of blankets, linen, and room.

H 45.42 Tetanus

(1) Patient

(a) Placard—None

(b) Restrictions—None

(c) Reporting required

(2) Contacts—No restrictions

(3) Environment

(a) Concurrent disinfection—None

(b) Terminal disinfection—None

H 45.43 Tinea Capitas (Ringworm Scalp)

(1) Patient

(a) Placard—None

(b) Restrictions—Exclusion from school until recovery unless

1. Under continuous treatment of physician licensed to practice medicine, and wears a suitable head covering until cured; or
2. Separate classroom provided for infected cases.

(c) Reporting required

(2) Contacts—Upon discovery of a clinical case of ringworm of the scalp, all contacts under 15 and all school children in the classroom should be inspected and examined with suitable filtered ultra-violet light. Resurveys should be continued until one month after last case is detected.

(3) Environment

(a) Concurrent disinfection—Stocking caps and inexpensive head coverings should be fre-

quently laundered and destroyed by burning after use.
(b) Terminal disinfection—None

H 45.44 Trachoma

(1) Patient
(a) Placard—None
(b) Restrictions — Isolation: None, if under medical supervision
(c) Reporting required
(2) Contacts—No restrictions
(3) Environment
(a) Concurrent disinfection of eye discharges and articles soiled therewith.
(b) Terminal disinfection—None

H 45.45 Trichinosis

(1) Patient
(a) Placard—None
(b) Restrictions—None
(c) Reporting required
(2) Contacts—No restrictions
(3) Environment
(a) Concurrent disinfection—None
(b) Terminal disinfection—None

H 45.46 Tularemia

(1) Patient
(a) Placard—None
(b) Restrictions—Isolation: None
(c) Reporting required
(2) Contacts—No restrictions
(3) Environment
(a) Concurrent disinfection of discharges from the ulcer, lymph glands, or conjunctival sac.
(b) Terminal disinfection—None

H 45.47–45.53 TYPHOID FEVER

H 45.47 Typhoid Fever—Patient

(1) Placard—Not required
(2) Restrictions—Isolation for at least one week beyond the time that all symptoms subside and until two negative, consecutive specimens of feces are obtained at least five days apart.
(3) Reporting required

H 45.48 Typhoid Fever—Contacts

(1) Quarantine—None
(2) Family contacts are not to be permitted to handle food during the period of contact nor before two negative, consecutive stool and urine cultures are obtained.

H 45.49 Typhoid Fever Cases—Environment

(1) Concurrent disinfection of all bowel and urinary discharges and articles soiled with them.
(2) Terminal disinfection through a thorough cleaning of the premises
(3) Suppression of flies

H 45.50 Typhoid Carrier—Definition

A person shall be considered a typhoid carrier, capable of transmitting the disease to susceptible persons if:

(1) During or following his convalescence from the disease his feces and/or urine have not been proved free from typhoid bacilli by examination in a laboratory approved for release cultures (temporary carrier).

(2) He has not suffered from typhoid fever within one year, but typhoid bacilli are found in his urine or feces when examined in a laboratory approved for release cultures (chronic carrier).

(3) Epidemiological evidence points to such person as the source of one or more cases of the disease and from whom for any reason specimens of urine or feces have not or cannot be obtained for examination in a laboratory approved for release cultures.

H 45.51 Typhoid Carriers—Rules Governing

(1) The urine and feces of a typhoid carrier shall be disposed of in such a manner as not to endanger any public or private water supply or be accessible to insects or rodents.

(2) If food products which are to be consumed raw by others are produced on premises occupied by a typhoid carrier, the water supply shall be proved free from contamination.

(3) No typhoid carrier shall engage in the handling or preparation of any food or drink to be consumed on the premises by others than members of his family with whom he resides or to be consumed off the premises prior to cooking. This restriction shall apply to visitors, roomers, lodgers, and employees.

(4) No typhoid carrier shall engage in the occupation of nurse, nursemaid, domestic servant, cook, waiter, dishwasher, or public eating-house employee.

(5) No typhoid carrier shall engage in any occupation involving the handling of milk, cream, or milk products, or the utensils used in the production thereof. No typhoid carrier shall reside on premises where milk is produced for distribution off the premises unless the carrier, or if he be a minor, his parent or legal guardian, and the owner of the milk-producing cows agree in writing:

(a) That the carrier will not engage in milking or handling of milk, cream, or dairy utensils, nor enter the house or barn where milk is produced or handled.

(b) That no milk or cream is subsequently to be sold nor any utensils used in the production of milk or cream shall be brought into the house occupied by the carrier.

(c) That all persons residing or employed on the premises who are susceptible to typhoid shall be vaccinated against typhoid fever at least every three years.

Where the provisions of such agreement are not followed, distribution and sale of milk from such premises are prohibited.

(6) No typhoid carrier shall reside in or be employed in a boarding house or camp.
(7) No carrier shall change his place of residence without notifying the local health officer of his intended residence, who shall immediately inform the state board of health of the facts.
(8) In any situation not covered by the above rules and in which a typhoid carrier endangers the public health, the carrier shall observe such recommendations as the state board of health may make for the particular case.

H 45.52 Typhoid Carriers—Release

Following isolation for typhoid fever a person adjudged a temporary carrier may be released from restrictions only after two successive specimens of feces, passed at an interval of not less than five days, shall have been examined in a laboratory approved for release cultures and found free from typhoid bacilli; except that if the person is to handle milk, dairy, or food products the number of negative cultures shall be four, two of which shall have been examined in a laboratory approved by the state board of health for release cultures.

H 45.53 Chronic Typhoid Carriers—Conditions for Release

(1) Each of at least 18 successive specimens of feces taken at intervals of 30 days under conditions that do not permit of substitution have been examined in a laboratory approved for release cultures by the state board of health and found to contain no typhoid bacilli.
(2) Where an individual has been found to be excreting the organisms through the urinary tract, then the requirements for release of carrier status under paragraphs H 45.52 and H 45.53 (1) shall apply for urine specimens as well.

H 45.54 Typhus

(1) Patient
  (a) Placard—None
  (b) Restrictions—Delousing, isolation in vermin-free room during febrile period.
  (c) Reporting required
(2) Contacts—Restrictions: None required if delousing carried out
(3) Environment
  (a) Concurrent disinfection—Use of insecticide powders on clothing and bedding and special treatment of hair for nits.
  (b) Terminal disinfection—None

H 45.55 Whooping Cough

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation for three weeks after onset of typical paroxysms, or a total of 28 days from onset of the catarrhal stage.
  (c) Reporting required
(2) Contacts—Restrictions: Other children in the family may attend school but are to be observed by the teacher and excluded if they evidence any symptoms of illness. Those children exposed to whooping cough who develop coughs or colds must be kept in isolation in their home until a diagnosis is established.
(3) Environment
  (a) Concurrent disinfection of the discharges from the nose and throat and of articles soiled with such discharges.
  (b) Terminal disinfection—A thorough cleaning of the premises

H 45.56 Yellow Fever

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation in a well-screened room for seven days
  (c) Reporting required on all cases to the local health officer within 24 hours.
(2) Contacts—Restrictions: Quarantine—None
(3) Environment—Concurrent disinfection: None except for the purpose of destroying mosquitoes in the house occupied by the patient and in the nearest neighboring dwellings.

H 46.01–H 46.03 TUBERCULOSIS

H 46.01 Tuberculosis—Patient

(1) Placard—None
(2) Restrictions
  (a) All individuals afflicted with tuberculosis of the lungs in the communicable form or reasonably suspected of being so afflicted shall exercise all reasonable precautions so as to prevent the infection of others with whom they may come in contact. The principal reasonable precautions are declared to be:
    1. Depositing sputum in a special receptacle and disposing of material by burning or thorough disinfecting.
    2. Preventing spraying when coughing by coughing into a container or paper napkin held to the mouth or nose.
    3. Using individual eating utensils sterilized by boiling after each use.
    4. Using separate towels.
    5. Sleeping alone.
    6. Avoiding coming in contact with other individuals on all possible occasions.
    7. Refraining from handling liquids or foodstuffs to be consumed by others or the utensils connected with such handling.
  (b) Any individual afflicted with tuberculosis of the lungs in the communicable form, diagnosed as such by a licensed physician or as shown by X-ray or the presence of tubercle bacilli in the sputum, in order to protect others from becoming infected, may be isolated on his premises by the local board of health or the health officer on the direction of the state board of health or state

health officer, or by the full-time medical health officer of any city or county with a population of 250,000 or more within his jurisdiction.

(c) A placard shall be posted in a conspicuous position on the premises, with the words "communicable disease" in letters not less than two inches high.

(d) The local board of health or health officer may employ as many persons as are necessary to execute its orders and properly guard any patient in isolation if isolation is violated or intent to violate isolation is manifested. Such persons shall be sworn in as guards, shall have police powers, and may use all necessary means to enforce the state laws for the prevention and control of communicable diseases, or for the enforcement of these rules and regulations.

(e) The expense of maintaining isolation, including examinations and tests to determine the presence or communicability of the disease, and the enforcement of isolation on the premises shall be paid by the city, incorporated village, or town upon order of the local board of health. The expenses for necessary nurses, medical attention, food, and other articles needed for the comfort of the afflicted person shall be charged against him or whoever is liable for his support. Indigent cases shall be cared for at public expense.

(f) Any individual who has been isolated on the premises under provision of these rules shall be released from such isolation by the local board of health or health officer on direction of the state board of health or state health officer or by the full-time medical health officer of any city or county with a population of 250,000 or more within his jurisdiction when in the opinion of said health officer the isolation is no longer necessary to protect others from becoming infected.

(g) No person with tuberculosis of the lung or other part of the respiratory tract in the communicable form, or reasonably believed to be suffering from such disease, shall be permitted to attend or frequent any school except open-air schools especially equipped for the purpose until the health officer of the municipality where the school is situated furnishes a written certificate stating that the individual is free from a communicable form of tuberculosis. Such certificate shall be issued only after thorough examination by a licensed physician in a manner satisfactory to the state board of health.

(h) If an individual afflicted with tuberculosis in a communicable form shall leave the sanatorium against the advice of the medical superintendent or medical supervisor, such an individual shall be reported to the local board of health and may be isolated upon his premises as provided in Section (b) if in the opinion of the state board of health or the state health officer or of the full-time medical health officer of cities or counties with a population of 250,000 or more, agree that isolation is necessary in order to protect others from becoming infected.

(i) The local health officer or an individual delegated by him shall visit all individuals isolated for tuberculosis at least once every 15 days to ascertain that the isolation is being maintained and to ascertain whether to make recommendations for release from isolation or for admission to a tuberculosis sanatorium.

(j) Any individual isolated for tuberculosis may obtain release from such isolation by being admitted to a tuberculosis sanatorium.

(k) Individuals afflicted with tuberculosis in any form and diagnosed as such by a competent physician shall exercise every care and precaution for the protection of others.

(3) Reporting—By name to local health officer

H 46.02 Tuberculosis—Contacts: No restrictions

H 46.03 Tuberculosis Cases—Environment: Disinfection

All handkerchiefs, towels, cloths, eating utensils and other contaminated material used by a person with tuberculosis shall receive appropriate disinfection before coming in contact with others. Upon the death or removal of a person with tuberculosis the health officer shall require disinfection of the premises occupied by the patient by a thorough washing of the woodwork by soap and water or a disinfectant, boiling of the dishes and contaminated fabrics, and a thorough sunning of material which cannot be subjected to other disinfection.

(Note: It is the intent of these rules and regulations to give reasonable protection to the public from exposure to an individual afflicted with pulmonary tuberculosis in the communicable form.)

H 47.01–47.12 VENEREAL DISEASES

H 47.01 Venereal Diseases

The state board of health declares the following venereal diseases, namely, syphilis, gonorrhea, and chancroid as contagious, infectious, communicable and dangerous to the public health.

H 47.02 Venereal Disease—All Infected Persons Subject to Control

All persons having venereal disease shall be subject to such control as public safety requires.

H 47.03 Venereal Disease—Who Is to Report

Any physician who attends, treats, or examines a person with venereal disease in communicable form; and any superintendent or manager of a hospital, dispensary, charitable or penal institution having knowledge of any such case not known to be previously reported, shall report such case to the state board of health. Such report shall be by designated number, age, sex, conjugal condition, and duration of disease. The physician shall inquire into the source of infection and shall report any person known to a reasonable certainty to be the source by name and address to the state board of health. Any person knowing of a case of venereal disease not under the care of a physician and believed to be a menace to the public health shall report the name and address directly to the state board of health.

H 47.04 Venereal Disease—Reporting of Cases Delinquent in Treatment

Whenever any person suffering from syphilis, gonorrhea or chancroid in a communicable form shall fail to return to the physician treating such person in reasonable time, such person shall be reported by name and address to the state board of health as delinquent in treatment.

H 47.05 Examination of Certain Classes Suspected of Having Venereal Disease

(1) It shall be the duty of each superintendent, manager or physician of any state, county, municipal, charitable, or correctional institution, the warden of the state prison, the sheriff, and other keepers of any jail or other penal institution to cause an examination to be made of all inmates suspected of having a venereal disease and said examination shall be made by a method satisfactory to the state board of health. Vagrants, prostitutes, frequenters of houses of prostitution, and persons guilty of illicit cohabitation are hereby declared to be reasonably suspected to have venereal disease.

(2) Any such person found to be infected with any of the venereal diseases in a communicable stage shall be kept in such quarters as not to expose others. Such persons and all legally committed persons with a venereal disease which is communicable to others, at expiration of commitment shall hereby be considered under quarantine and shall so remain until satisfactory arrangements can be made for care and treatment by a licensed physician at place of subsequent residence or until other disposition of the case is made by the state board of health.

H 47.06 Venereal Disease Cases—Isolation

Whenever a case or suspected case of venereal disease is found on premises where the case cannot be properly controlled during the period of infectiousness, or whenever a case of venereal disease in the infectious stage refuses or neglects care or treatment by a physician licensed to prescribe drugs, or is unmanageable and other persons are endangered, a placard may be placed on the premises occupied by the patient. Such placard shall be applied in emergency and not in lieu of commitment to an institution under Chapter 143.07, Laws of Wisconsin. The placard sign shall have the words "Communicable Disease." Violation of the requirements imposed by the placard shall be deemed a violation of these regulations. The local health officer shall be required by the state board of health to impose such isolation and enforce its requirements.

H 47.07 Venereal Disease—Examination of Sexual Contacts

All persons reported to be sexual contacts by any person with venereal disease in a communicable form shall be regarded as suspected cases and may be required by an official of the state board of health to be examined by a physician, in a manner satisfactory to the state board of health.

H 47.08 Venereal Disease—Indigents: Treatment Facilities

Local health officers and local boards of health shall cooperate with the state board of health in establishing treatment facilities for indigent persons with venereal disease. Local health officers shall report to the state board of health all cases of venereal disease reported to them.

H 47.09 Venereal Disease—Forbidden Occupations

Persons suspected to be or knowing themselves to be afflicted with a communicable venereal disease shall not engage in the care or nursing of children or of the sick, nor shall they engage in any occupation the nature of which is such that their infection may be communicated to others. In the interest of the public health a medical health officer or officer of the state board of health may confidentially inform any person so endangered.

H 47.10 Issuing Certificates of Freedom From Venereal Disease Forbidden

No physician or health officer shall issue certificates of freedom from any venereal disease to any person except those certificates required by law for marriage licenses and those required by local ordinances to be issued to local health officers. No person shall carry or exhibit such certificates to other persons or show, for immoral purposes, venereal disease reports from any laboratory. Such procedure is declared by the state board of health to be inimical to public health and public welfare.

H 47.11 Venereal Disease—Minors

The parents or guardians of minors acquiring venereal disease shall, when notified, be legally responsible for the compliance of such minors with the requirements of these regulations.

H 47.12 Venereal Disease—Definition of Communicability

All cases of venereal disease shall be regarded as communicable until the following requirements have been met:

(1) **Syphilis*** Until open sores, ulcers, rashes, syphilitic sore throat, or other open syphilitic lesions are healed; and also until satisfactory care and treatment as hereinafter defined has been given to any of the following: Pregnant women with syphilis; females who have given birth to a syphilitic child; syphilitic persons at any stage of the disease who, reasonable evidence indicates, are promiscuous in sexual relations and are a menace to others; and persons with early syphilis not adequately treated.

(Note: Adequate treatment shall be considered to be the administration of not less than 20 doses of arsenicals and 20 doses of heavy metal or equally effective treatment by a physician licensed to prescribe drugs. This other effective treatment shall be such as considered adequate by the state board of health.)

(2) **Gonorrhea**

(a) Male

1. Freedom from discharge
2. Clear urine, no shreds
3. Urethral smears must be negative for gonococci on four successive examinations at intervals of not less than one week.
4. Prostatic smears negative to gonococci on two successive tests, not less than one month after conclusion of specific treatment.
5. When penicillin is used for the treatment of gonorrhea, a blood test for syphilis shall be taken at monthly intervals for a three-month period.

(b) Female

1. No unusual vaginal discharge
2. Two successive negative examinations for gonococci of the secretions of the urethra, vagina, and of the cervix with an interval of at least 48 hours, and repeated for four successive weeks.
3. When penicillin is used for the treatment of gonorrhea, a blood test for syphilis shall be taken at monthly intervals for a three-month period.

(Note: The labia should be held apart and a swab applied so as to express any secretions from Skenes or Bartholin's glands, which is then taken up on the swab.

In preparing urethral slides the finger should be inserted in the vagina and expression made on the floor of the urethra from within outward, the cotton-tipped probe being then introduced well into the meatus. In procuring a smear from the cervix a vaginal speculum should be introduced and the cervix well exposed. All secretions should be mopped away from the external os before taking the smear. After the cervix is well dried a probe tightly wound with cotton should be inserted in the cervical canal and rotated several times.)

(3) **Chancroid.** Until all lesions are healed.

H 49.01 School Attendance

(1) All teachers, school authorities, and health officers having jurisdiction shall not permit the attendance in any private, parochial, or public school of any pupil afflicted with a severe cough, a severe cold, itch, scabies, lice or other vermin, ringworm, impetigo, epidemic jaundice, Vincent's angina (trench mouth), infectious conjunctivitis (pink eye), or any contagious skin disease, or who is filthy in body or clothing, or who has any communicable disease so designated by the state board of health unless specifically exempted in the rules. The teachers in all schools shall, without delay, send home any pupil who is obviously sick even if the ailment is unknown, and said teacher shall inform the parents or guardians of said pupil and also the local health officer as speedily as possible, and said health officer shall examine into the case and take such action as is reasonable and necessary for the benefit of the pupils and to prevent the spread of infection.

(2) Parents, guardians, or other persons having control of any child who is sick in any way, or who is afflicted with any disease covered by this rule, shall not permit said child to attend any public, private or parochial school or to be present in any public place.

H 49.02 Exclusion From School, Assemblages, and Public Conveyances

No person suffering from any communicable disease so designated by the state board of health shall be admitted to any public, parochial, or private school, college, or Sunday School, or shall enter any theatre, assemblage, or railway car, street car, vessel, or steamer, or other public conveyance, except as specifically provided in the communicable disease rules.

H 49.03 Books not to be Taken into Infected Homes

(1) Schoolbooks or books from public or circulating libraries shall not be taken into any house placarded for communicable disease and if schoolbooks or library books have already been taken in such house they shall be destroyed by the owner or library authorities or thoroughly disinfected.

(2) Disinfection of books—In cases where it is desirable to disinfect books which may have become infected with dangerous communicable disease the following requirements must be followed:

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* *Does not apply to Section 143.07, subsection 4.*

(a) Library books which have been in a placarded home should be withheld from circulation for a period of 15 days and so arranged each day that the sunlight can reach the maximum number of surfaces.

(b) Books used by a tubercular person should either be destroyed or withheld from circulation for at least one month and during this time kept standing in the sunlight opened so that the rays of the sun can reach the maximum number of pages. Surfaces should be changed from day to day. Time and sunlight are recommended as the best means to accomplish the destruction of infectious material deposited upon books.

H 49.10 Sale of Milk and Dairy Products from Infected Home Restricted

The sale or use of milk and dairy products from a place where cholera (Asiatic), diphtheria, plague, smallpox, respiratory streptococcal infections (including scarlet fever and streptococcal sore throat), typhoid fever, paratyphoid fever, or other salmonella disease is found to exist is strictly forbidden unless the milk is handled, milk utensils washed and stock cared for and the product transported by persons disassociated from the infected individual. The adequacy of such disassociation shall be determined by the local health officer or the state board of health. The handling by the infected person of milk or milk products for sale, or stock, equipment, or other utensils used to produce such products is forbidden under any circumstances.

H 49.15 Release Cultures

Where release cultures are required in communicable diseases, such cultures shall be examined in a laboratory approved by the state board of health for such purposes.

H 49.20 Transporting Cases

When it is necessary to transport a person suffering with a dangerous communicable disease from one town, village or city to another, the consent of the health officer where the patient lives and to which the patient will be transported must first be obtained. Transportation must be made by private conveyance and proper precautions exercised to prevent needless exposure of all persons who may come in contact with the patient during transit.

H 49.25 Mail in Placarded Home

No mail or other materials shall be sent from a placarded home unless such mail or materials have been prepared and disinfected under the direction of the local health officer.

H 17.06 Public Funerals Prohibited

(1) Public or church funerals shall not be held for persons dead of smallpox. Every person who attends the funeral, including members of the family, shall, within 24 hours of attending the funeral or exposure, submit to vaccination for smallpox or produce evidence from a physician of successful vaccination within the past two years.

(2) Whenever death is due to cholera (Asiatic), diphtheria, poliomyelitis, plague, or scarlet fever, the household and family contacts of the deceased shall not be permitted to attend public or church funerals for the deceased nor to have any association with the public until the specific restrictions governing contacts have been fulfilled.

(3) The above rules shall apply to funerals of those dead from suspected cases as well as diagnosed cases of the diseases above specified, but shall not apply to those dying from late complications of such diseases after the communicable period is past, and after the family is released from quarantine.

(4) During periods of epidemic, diseases of any nature found sufficiently malignant to justify private funerals and in the case of death from unusual forms of virulent disease, apparently communicable in nature, the local board of health with the consent of the state board of health may prohibit public funerals of those dead from such diseases.

Rules Governing Approval of Laboratories for Doing Serological Tests as Required by the Marriage License Law (Chapter 245.10)

H 37.01 Upon application, a laboratory may be approved as competent to make the serological tests required prior to marriage under *chapter 245.10*, provided that:

(1) The laboratory is under the adequate supervision of a licensed doctor of medicine who is a recognized pathologist; or

(2) The laboratory has had a thorough evaluation by the Board covering qualifications of personnel, supervision, physical equipment, and the techniques and procedures used by the laboratory.

H 37.02 Whenever the Board is in doubt as to the character or extent of the supervision provided under subparagraph **H 37.01 (1)**, the evaluation provided under subparagraph **H 37.01 (2)** shall precede the approval of the laboratory.

H 37.03 If there is change in directorship or supervision of the laboratory it must be reported to the state board of health and the laboratory must reapply for approval.

H 37.04 The Board may withdraw approval of a laboratory upon the submission of evidence satisfactory to the Board that the extent or character of the laboratory supervision is inadequate or that quality of the work performed by the laboratory is not up to acceptable standards.

Instructions for the Use of Wisconsin State Laboratory of Hygiene

University of Wisconsin—Laboratory of the State Board of Health

Location of Laboratory

State Laboratory of Hygiene Building, 437 Henry Mall, Madison 6, Wisconsin

Working Hours

Monday through Saturday—7:45 a.m. to 4:30 p.m.
Sundays—8:30 a.m. to 12 noon
Holidays—7:45 a.m. to 12 noon

Telephone—Alpine 6-6811, Extension 511 or Extension 513.

General Information

Submitting Specimens: The value of a laboratory examination depends as much on the quality of the specimen as upon technic in the laboratory. A poorly collected and improperly prepared specimen cannot be expected to yield reliable information. Physicians, health officers, nurses, medical technologists, sanitarians, sanitary engineers, and veterinarians are therefore urgently requested to see that every specimen sent to the laboratory is collected according to the instructions furnished with the specimen outfits. They should complete the specimen information blank in the outfit, including the exact information desired and a very brief clinical history if indicated. This blank is to be enclosed with the freshly collected specimen in the mailing case and the entire outfit mailed promptly.

WRITE PLAINLY to insure accuracy in transcribing the name of the patient as well as the name and address of the sender. The importance of a legibly filled-in form cannot be overemphasized. Printed or typewritten information is desirable.

The use of **antibiotic therapy** before collecting specimens for culture may result in the inability of the laboratory to isolate the causative agent. If specimens are submitted after treatment with antibiotics, a statement to that effect should be made on the data sheet, naming the antibiotic used.

Specimens should be submitted PROMPTLY after collection.

Mail Service and Postage Rates on Specimens: Federal laws require that all material of this nature sent through the mail must be packed in double mailing containers in an inside tin and an outside mailing carton.

Specimens submitted in the outfits provided by the State Laboratory of Hygiene and accompanied by the regulation data sheets may be mailed at fourth-class postage rates (parcel post), PROVIDED no communication other than that called for on the data sheet is included. Postage and express charges must be paid by the sender.

WEEK-END SERVICE. Specimens mailed to the laboratory either Friday or Saturday may remain in the post office over Sunday. In order to avoid spoilage and hemolysis, blood specimens should be sent by special delivery or refrigerated until they are mailed. This precaution is especially important during hot or very cold weather.

Mailing containers, which are sent free upon request, are expensive; and only those necessary for short periods of time should be requested. They should be used only for returning specimens to this laboratory for examination.

Laboratory Records and Reports: LABORATORY RECORDS ARE CONFIDENTIAL. No information is given except upon receipt of written permission from the sender of the specimen.

Reports by wire are sent collect and only upon request. This request may be written on the data sheet, provided first-class postage is used on the package. Reports on certain examinations are usually mailed within 12 to 24 hours from the time the specimen is received. Cultures require more time, and occasional preliminary reports are sent.

The Interpretation of Laboratory Findings: The laboratory test serves to supplement, and sometimes confirm, clinical observations. At times a positive laboratory finding may be conclusive; but there are many conditions in which it may not be, and such interpretation should be made with caution. Negative findings should not be accepted as conclusive. Additional specimens should be submitted when the laboratory findings are doubtful or questionable. In establishing the etiology of certain communicable diseases, the demonstration of a definite rise in antibody titer (by agglutination or complement fixation tests) is of more significance than the results of the test on a single sample of blood. For this reason, two samples of blood—acute phase and convalescent phase—should be submitted in suspected cases of virus and rickettsial diseases.

Laboratory Approval: Any laboratory established and operated to perform examinations of milk and water for the purpose of protecting the health of the public may apply to the State Board of Health, Madison 2, Wisconsin, for an evaluation and appropriate approval of their laboratory procedures. Evaluations are based on conformity of technic, equipment, and quarters with requirements listed in the current edition of Standard Methods as well as on personnel training and experience.

Guide for Submitting Specimens

ANTISTREPTOLYSIN

Submit 5 cc. blood in STERILE SCREW-CAPPED VIAL (see p. 106). Special precautions are necessary in collecting the specimen. Please request information sheet from laboratory.

BACILLARY DYSENTERY

(Shigella Infection)

Submit feces in STOOL CULTURE OUTFIT, which contains buffered glycerol-saline solution (see page 106). A small quantity of fecal material should be mixed with the fluid in the vial. If SHIGELLA infection is suspected, a rectal swab should be taken and placed in the vial containing the preservative. Intestinal parasite and sputum containers are not satisfactory.

BLOOD CHEMISTRY*:

Amylase

Submit 3 to 4 ml. SERUM in BLOOD CHEMISTRY OUTFIT (see p. 106). Anticoagulant and preservative must be THOROUGHLY removed from the vial. Normal range depends upon the starch substrate employed and will accompany each report.

Bilirubin

Submit 3 to 4 ml. SERUM in BLOOD CHEMISTRY OUTFIT (see p. 106). Anticoagulant and preservative must be THOROUGHLY removed from the vial.

Normal range: Direct—.1 to .2 mg. per cent.
Total—Up to 1.2 mg. per cent

Bromides

Submit 3 to 4 ml. SERUM in BLOOD CHEMISTRY OUTFIT (see p. 106). Anticoagulant and preservative must be THOROUGHLY removed from the vial.

Calcium

Submit 3 to 4 ml. SERUM in BLOOD CHEMISTRY OUTFIT (see p. 106). Anticoagulant and preservative must be THOROUGHLY removed from the vial.

Normal range—9 to 11.1 mg. per cent.

Carboxyhemoglobin

Submit 4 ml. of whole blood in BLOOD CHEMISTRY OUTFIT (see p. 106). Sodium fluoride and thymol, used as anticoagulant and preservative, are in the vial. Mix well gently.

Chlorides as NaCl

Submit 3 to 4 ml. SERUM in BLOOD CHEMISTRY OUTFIT (see p. 106). Anticoagulant and preservative must be THOROUGHLY removed from the vial.

Normal range—570 to 620 mg. per cent.

Cholesterol

Submit 3 to 4 ml. SERUM in BLOOD CHEMISTRY OUTFIT (see p. 106). Anticoagulant and preservative must be THOROUGHLY removed from the vial.

Normal range—150 to 250 mg. per cent

Creatinine

Submit 4 ml. of WHOLE BLOOD in BLOOD CHEMISTRY OUTFIT (see p. 106). Sodium fluoride and thymol, used as anticoagulant and preservative, are in the vial. Mix well gently.

Normal range—1 to 2 mg. per cent.

Icteric Index

Submit 3 to 4 ml. SERUM in BLOOD CHEMISTRY OUTFIT (see p. 106). Anticoagulant and preservative must be THOROUGHLY removed from the vial.

Normal range—4 to 6 units.

Lead

Submit 15 to 20 ml. WHOLE BLOOD in specially prepared glass tubes. The syringe and container must be washed with nitric acid and rinsed with distilled water. If these outfits are to be supplied by the laboratory, please make special request.

Normal range—Up to .05 mg. per cent.

Lipase

Submit 3 to 4 ml. SERUM in BLOOD CHEMISTRY OUTFIT (see p. 106). Anticoagulant and preservative must be THOROUGHLY removed from the vial.

Normal range—Up to 1.5 units.

Nonprotein Nitrogen

Submit 4 ml. of WHOLE BLOOD in BLOOD CHEMISTRY OUTFIT (see p. 106). Sodium fluoride and thymol, used as anticoagulant and preservative, are in the vial. Mix well gently.

Normal range—25 to 40 mg. per cent.

Methemoglobin

Submit 4 ml. of WHOLE BLOOD in BLOOD CHEMISTRY OUTFIT (see p. 106). Sodium fluoride and thymol, used as anticoagulant and preservative, are in the vial. Mix well gently.

Phosphatase, Acid

Submit 3 to 4 ml. SERUM in BLOOD CHEMISTRY OUTFIT (see p. 106). Anticoagulant and preservative must be THOROUGHLY removed from the vial.

Normal range—2.5 to 3.5 King-Armstrong units. (Below 6 units, prostatic cancer is either absent or confined to the gland).

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* These determinations, except blood sugar, cannot be done as routine procedures; and they can be done only in those instances where the facility is not available in the local community either through hospital or other laboratory of pathology.

Phosphatase, Alkaline

Submit 3 to 4 ml. SERUM in BLOOD CHEMISTRY OUTFIT (see p. 106). Anticoagulant and preservative must be THOROUGHLY removed from the vial.

Normal range—Below 13 King–Armstrong units.

Phosphorus, Inorganic

Submit 3 to 4 ml. SERUM in BLOOD CHEMISTRY OUTFIT (see p. 106). Anticoagulant and preservative must be THOROUGHLY removed from the vial.

Normal range—3 to 4 mg. per cent.

Potassium

Submit 3 to 4 ml. SERUM in BLOOD CHEMISTRY OUTFIT (see p. 106). Anticoagulant and preservative must be THOROUGHLY removed from the vial. Serum must be removed from clot within one hour later after blood is drawn.

Normal range—16 to 22 mg. per cent.

Protein

Submit 3 to 4 ml. SERUM in BLOOD CHEMISTRY OUTFIT (see p. 106). Anticoagulant and preservative must be THOROUGHLY removed from the vial.

Normal range—Total—6.0 to 8.0 per cent.
Albumin—3.5 to 5.5 per cent.
Globulin—1.5 to 3.0 per cent.
Gamma globulin— .6 to 1.1 per cent.

Protein Bound Iodine

Submit 3 to 4 ml. SERUM in BLOOD CHEMISTRY OUTFIT (see p. 106). Anticoagulant and preservative must be THOROUGHLY removed from the vial.

Normal range—4 to 6.5 micrograms per cent.
Hyperthyroid—8 to 48 micrograms per cent.
Hypothyroid—0 to 3 micrograms per cent.

Sodium

Submit 3 to 4 ml. SERUM in BLOOD CHEMISTRY OUTFIT (see p. 106). Anticoagulant and preservative must be THOROUGHLY removed from the vial. Serum must be removed from clot within one hour after blood is drawn.

Normal range—315 to 340 mg. per cent.

Sugar

Submit 4 ml. WHOLE BLOOD in BLOOD CHEMISTRY OUTFIT (see p. 106). Sodium fluoride and thymol, used as anticoagulant and preservative, are in the vial. Mix well gently.

Normal range—70 to 120 mg. per cent.

Sulfhemoglobin

Submit 4 ml. WHOLE BLOOD in BLOOD CHEMISTRY OUTFIT (see p. 106). Sodium fluoride and thymol, used as anticoagulant and preservative, are in the vial. Mix well gently.

Thiocyanate

Submit 3 to 4 ml. SERUM in BLOOD CHEMISTRY OUTFIT (see p. 106)). Anticoagulant and preservative must be THOROUGHLY removed from the vial.

Normal range—.03 to .06 mg. per cent.

Trypsin (Glycine)

Submit PLASMA in BLOOD CHEMISTRY OUTFIT (see p. 106). The secretion of trypsin is best indicated by the determination of the glycine blood level after the administration of gelatin.

(1) Instruct the patient to eat no food for at least six hours before the test. (2) Draw 5 ml. fasting blood and place in centrifuge tube containing sodium or potassium oxalate; mix well. Blood must not be permitted to coagulate. (3) Feed patient 1 Gm. of Knox gelatine per kilogram of body weight suspended in warm water. (4) Two and one-half hours later draw 5 ml. blood and place in centrifuge tube containing oxalate. Mix well. (5) Centrifuge both specimens and transfer plasma to BLOOD CHEMISTRY VIAL after THOROUGHLY removing the preservative found in all of these vials. Label No. 1 "Fasting" and No. 2 "After gelatin." Request glycine determination.

Normal level—1 to 2.5 mg. per cent. Normal tryptic activity will increase the glycine level twofold to threefold.

Urea

Submit 4 ml. of WHOLE BLOOD in BLOOD CHEMISTRY OUTFIT (see p. 106). Sodium fluoride and thymol, used as anticoagulant and preservative, are in the vial. Mix well gently.

Normal range—12 to 20 mg. per cent.

Uric Acid

Submit 4 ml. of WHOLE BLOOD in BLOOD CHEMISTRY OUTFIT (see p. 106). Sodium fluoride and thymol, used as anticoagulant and preservative, are in the vial. Mix well gently.

Normal range—2 to 3.5 mg. per cent.

CHANCRE

Submit specimen for Darkfield examination in special capillary tubes which are supplied in mailing cartons with instruction for their use.

CHANCROID

Submit thin smears of pus from lesion on glass slides available in SLIDE OUTFIT (see p. 106); or if culture is desired, submit pus in STERILE SCREW-CAPPED VIAL (see p. 106).

CONJUNCTIVITIS

Submit smear of pus or exudate on slide in SLIDE OUTFIT (see p. 106). Mark "Eye Smear." Material for general culture may be submitted on swab in THROAT CULTURE OUTFIT. Mark "Eye Culture for Organisms."

DIPHTHERIA

For diagnosis, release from quarantine, or detection of carrier, collect material from nose and throat on sterile swabs in THROAT CULTURE OUTFIT (see p. 106). No media necessary; organisms survive well.

ECHINOCOCCUS

Submit blood in STERILE SCREW-CAPPED VIAL (see p. 106); or if surgery is done, transmit cyst if possible.

FOOD INFECTIONS

(Salmonella or paratyphoid infection)

1. Submit feces for culture in STOOL CULTURE OUTFIT (see p. 106).

2. Clotted blood may be sent in STERILE SCREW-CAPPED VIAL (see p. 106), for culture for bacteremia during the first week of illness.

FOOD POISONING

Where staphylococcus or botulinus toxins may be involved, rush refrigerated samples of all suspected foods, and feces from patients for culture in STOOL CULTURE OUTFIT (see p. 106), to the laboratory accompanied by an accurate description of symptoms. State if botulism is suspected.

FUNGUS INFECTIONS

Epidermophytons

Hair, skin and nail scrapings, pleural fluid, drainage from lesions, and sputum may be sent in STERILE SCREW-CAPPED VIALS (see p. 106) for miscroscopic studies.

Blastomycosis

Submit portion of curettings from lesion in STERILE SCREW-CAPPED VIALS (see p. 106) for culture. Tissue biopsy in 10 per cent Formalin may be submitted for microscopic examination.

Histoplasmosis

Sputum in SPUTUM OUTFIT (see p. 106) for culture. Blood in STERILE SCREW-CAPPED VIAL for complement fixation test.

Toxoplasmosis

Blood in STERILE SCREW-CAPPED VIAL (see p. 106). Due to the relative frequency of toxoplasmosis antibodies in adults, the results of serological tests cannot be reliably interpreted. Serological tests will be done only in suspected cases of congenital toxoplasmosis.

GONORRHEA

Submit thin smear of discharge on glass slide in SLIDE OUTFIT (see p. 106). Allow smear to dry thoroughly before mailing.

HEMOLYTIC STREPTOCOCCUS

Inoculate sterile swabs in THROAT CULTURE OUTFIT (see p. 106). No media necessary; organisms survive well on swabs.

INFECTIOUS MONONUCLEOSIS

(Glandular fever)

After first week of disease, submit blood specimen in STERILE SCREW-CAPPED VIAL (see p. 106). If first specimen is negative, test should be repeated.

INTESTINAL PARASITES

Amebiasis

1. In the acute stage, with passage of loose or dysenteric stools, send patient to laboratory for warm stool examination if possible. Otherwise, submit feces in PVA OUTFIT (see p. 106).

2. In the chronic stage, with passage of formed stools, submit feces in INTESTINAL PARASITE OUTFIT (see p. 106), or any clean screw-cap vial may be used. (If an examination for amebiasis is desired, make specific request on data sheet).

3. Submit blood in STERILE SCREW-CAPPED VIAL (see p. 106) for complement fixation test.

Protozoan Infestations (Entamoeba histolytica and others)

Submit feces or urine in INTESTINAL PARASITE OUTFIT (see p. 106) or any clean screw-capped vial.

Worms

1. Submit feces for all worms except PINWORM in INTESTINAL PARASITE OUTFIT (see p. 106).

2. For PINWORM use PINWORM OUTFIT (see p. 106) to collect material from the perianal folds.

3. Submit worms or segments in 10 per cent Formalin.

LEPTOSPIROSIS

Submit blood in STERILE SCREW-CAPPED VIAL (see p. 106). Two specimens should be submitted—first specimen as early as possible after onset of the disease and second specimen ten days to two weeks later. Single specimen is not significant. Submit brief history.

LYMPHOPATHIA VENEREUM

Submit blood as for syphilis tests. Mark "For Lymphopathia Venereum Complement Fixation Test."

MALARIA

Submit thick and thin blood films on glass slides in SLIDE OUTFIT (see p. 106). Allow films to dry thoroughly in horizontal position before mailing.

MALIGNANT NEOPLASMS

Papanicolaou smears

Specimens should be submitted in PAPANICOLAOU OUTFIT (see p. 106) according to instructions enclosed therein.

Biopsies*

Tissue submitted in 10 per cent formaldehyde. No special containers supplied. Special data sheets are available for information desired in the laboratory. Specimens may be submitted where histology of the lesion or microscopic examination of tissue may be helpful in the identification of the causative organisms—that is, tuberculosis, fungi, etc.—and neoplasms.

MENINGITIS

Submit spinal fluid for culture in STERILE SCREW-CAPPED VIAL (see p. 106). Cell counts are not done.

PARATYPHOID

(Salmonella)

1. Submit blood for agglutination tests and culture in STERILE SCREW-CAPPED VIAL (see p. 106).

2. Submit feces for diagnosis, release from quarantine, or detection of carrier in STOOL CULTURE OUTFIT (see p. 106), which contains buffered glycerol-saline solution. Intestinal parasite and sputum containers are not satisfactory.

RABIES IN ANIMALS

Pack only the head of the animal in a clean can. Seal and pack with ice in a larger can. Ship by express or bring to the laboratory. DO NOT MAIL. Information should be supplied concerning persons bitten, giving the location and severity of the wounds and a history of the animal.

RH AND BLOOD GROUP TESTS

This work is limited to prenatal and closely related cases. Submit blood specimen in STERILE SCREW-CAPPED VIAL (see p. 106).

Blood Group Genetic Pattern (Homozygous or Heterozygous)

Submit, in STERILE SCREW-CAPPED VIALS (see p. 106), blood from wife, husband and children.

Determination of Nonparentage

Submit, in STERILE SCREW-CAPPED VIALS (see p. 106), blood from mother, child, and alleged father. This test is done where legal action is anticipated only upon the request of the court. This laboratory does not go into court on either side of any given case.

SPINAL FLUID CHLORIDES

Submit 2 to 3 ml. in STERILE SCREW-CAPPED VIAL (see p. 106).

Normal range—625 to 760 mg. per cent in children.
720 to 750 mg. per cent in adults.

* Where a local pathologist is available, this laboratory should be used for consultation only.

SPINAL FLUID PROTEINS

Submit 2 to 3 ml. in STERILE SCREW-CAPPED VIAL (see p. 106).

Normal range—30 mg. per cent.

SYPHILIS

1. In primary stage, from open primary chancre, submit the exudate—free of pus, red blood cells, and detritus—in DARKFIELD OUTFIT (see p. 106). See instructions enclosed therein.

2. In other stages of the disease, submit blood in RUBBER-STOPPERED VIAL (see p. 106).

3. Requests for premarital blood tests should be noted on the data sheet. Submit blood as in 2 above.

4. In cases of unexpected serologic results or suspected false positive reactions, repeat tests should be done. Submit blood in RUBBER-STOPPERED VIAL (see p. 106).

5. Spinal fluids, free of blood, may be submitted for serologic test, gold Sol, and total protein determination. Submit immediately after collection, in STERILE SCREW-CAPPED VIAL (see p. 106), not less than 5 ml. of fluid.

TRICHOMONAS VAGINALIS

Vaginal smear may be made on slide available in SLIDE OUTFIT (see p. 106). Mark "For Trichomonads."

TRICHINOSIS

Examination for Trichinella spiralis larvae will be made on biopsy tissue or suspected meat or meat products.

Complement fixation test and precipitation test on blood may be obtained. Submit blood in STERILE SCREW-CAPPED VIAL (see p. 106).

TUBERCULOSIS

1. Submit sputum or other exudates to be examined for tubercle bacilli in SPUTUM OUTFIT (see p. 106).

2. Gastric lavage should be submitted in GASTRIC OUTFIT (see p. 106). Instructions enclosed therein.

3. Submit 2 to 3 ml. of spinal fluid in STERILE SCREW-CAPPED VIAL (see p. 106).

4. Sensitivity of tubercle bacilli to antibiotics is also determined upon request.

TULAREMIA

Submit blood for agglutination test in STERILE SCREW-CAPPED VIAL (see p. 106).

TYPHOID

1. Submit blood for culture and agglutination test in STERILE SCREW-CAPPED VIAL (see p. 106).

2. Submit feces for diagnosis, release from quarantine, or detection of carrier in STOOL CULTURE OUTFIT, which contains buffered glycerol-saline solution (see p. 106). Intestinal parasite and sputum containers are not satisfactory.

UNDULANT FEVER

(Brucellosis)

Submit blood for agglutination test and culture in STERILE SCREW-CAPPED VIAL (see p. 106). Clot culture will be done when serum shows complete or partial agglutination in 1:40 dilution.

URINE

Arsenic

Submit 100 to 200 ml. urine. Containers not provided by laboratory.

Normal, 0. In chronic arsenic poisoning .5 Gm. of hair cut close to the skin should be submitted. Normal, up to 5 micrograms per Gm. of hair.

17-Ketosteroids

Total 24-hour secretion must be known and a 200-ml. specimen submitted for examination; 5 ml. per liter of urine is preserved with a mixture of equal parts of toluene, glacial acetic acid, and chloroform.

Normal values—Children, less than 1 mg. The amount increases up to 18 years of age. Adult females—5 to 15 mg. Adult males—7 to 20 mg. up to 50 years of age. Values below 5 mg. commonly found in elderly men.

Lead

Submit 200 ml. Container should be washed with nitric acid and rinsed several times with distilled water. Containers provided by laboratory upon special request.

Normal level, up to .05 mg. per liter.

Mercury

Submit 100 to 200 ml. Containers provided by laboratory upon special request.

Normal, 0.

VIRUS AND RICKETTSIAL DISEASES

Influenza

Complement fixation test and hemagglutination-inhibition. Submit blood in STERILE SCREW-CAPPED VIAL (see p. 106). Submit two specimens —first specimen as early as possible after onset of the disease and second specimen ten days or two weeks later. Single specimen not significant. Submit brief history. When isolation of a virus is desired, the laboratory should be contacted for instructions.

Mumps

Complement fixation test. Hemagglutination-inhibition. Submit blood in STERILE SCREW-CAPPED VIAL (see p. 106). Submit two specimens —first specimen as early as possible after onset of disease and second specimen ten days or two weeks later. Single specimen not significant. Submit brief history. When isolation of a virus is desired, the laboratory should be contacted for instructions.

Psittacosis—Lymphogranuloma Venereum group

Complement fixation test. Submit two specimens of blood in STERILE SCREW-CAPPED VIALS (see p. 106)—first specimen as early as possible after onset of the disease and second specimen two to three weeks later. Single specimen not significant. Submit brief history.

Western Equine Encephalomyelitis

Complement fixation test. Submit two specimens of blood in STERILE SCREW-CAPPED VIALS (see p. 106)—first specimen as early as possible after onset of the disease and second specimen ten days or two weeks later. Single specimen not significant. Submit brief history.

Eastern Equine Encephalomyelitis

Complement fixation test. Submit specimens as for western equine encephalomyelitis.

St. Louis Encephalitis

Complement fixation test. Submit specimens as for western equine encephalomyelitis.

Lymphocytic Choriomeningitis

Complement fixation test. Submit specimens as for western equine encephalomyelitis.

Primary Atypical Pneumonia

Cold hemagglutination. Submit blood in STERILE SCREW-CAPPED VIAL (see p. 106) during second to fourth week of illness. Submit brief history.

Rickettsialpox

Complement fixation test. Submit specimens as for western equine encephalomyelitis.

Q Fever

Complement fixation test. Submit specimens as for western equine encephalomyelitis.

Rocky Mountain Spotted Fever

Complement fixation test. Weil-Felix agglutination test. Submit two specimens of blood in STERILE SCREW-CAPPED VIAL (see p. 106)—first specimen as early as possible after onset of the disease and second specimen two to three weeks later. Submit brief history.

Epidemic Typhus

Submit specimens as for Rocky Mountain spotted fever.

Endemic Typhus

Submit specimens as for Rocky Mountain spotted fever.

Isolation of Viruses

(Poliomyelitis, Coxsackie, Herpes Simplex, Influenza, etc.)

Contact the laboratory for special instructions concerning the collection of specimens for this purpose.

SANITATION

Water Bacteriology

Submit sample of water in WATER BACTERIOLOGY OUTFIT, according to enclosed instructions, for purity, hardness, iron, or fluorine determinations.

Water Chemistry

WATER CHEMISTRY OUTFIT sent only to State engineers or on special request.

MISCELLANEOUS EXAMINATIONS

Special arrangements should be made with the laboratory. A brief case history should be submitted with specimens, and information should specifically include the material submitted and examination desired.

Instructions from Communicable Disease Center Laboratories at Chamblee, Georgia, are that physicians wishing to use that laboratory must send the specimens through the State Laboratory of Hygiene. If we do not do the test, we will forward it to the Communicable Disease Center. If specimen is destined for C.D.C., brief clinical manifestations must accompany the request.

Outfits

To secure satisfactory specimens for examination, the following special outfits are furnished free of charge upon request:

1. PINWORM OVA OUTFIT—containing cellophane tape slide for obtaining material from the perianal folds to be examined for pinworm ova.
2. DARKFIELD OUTFIT—for exudates to be examined for syphilis spirochetes.
3. INTESTINAL PARASITE OUTFIT—for ova of intestinal parasites (unsatisfactory for cultures).
4. RUBBER-STOPPERED VIAL—for syphilis serology.
5. BLOOD CHEMISTRY OUTFIT—for blood chemistry determinations; contains a powder for preservative.
6. PVA OUTFIT—for loose or dysenteric stools to be examined for acute amebiasis.
7. SLIDE OUTFIT—for thick or thin blood smears for malaria, pus smears, gonorrheal smears, and miscellaneous smears.
8. SPUTUM OUTFIT—for sputum and other exudates to be examined for tubercle bacilli.
9. STERILE SCREW-CAPPED VIALS—for blood for Rh factor determinations, agglutination tests, blood cultures, and other tests where blood is required, and for pus and other miscellaneous materials.
10. STOOL CULTURE OUTFIT—containing buffered glycerol-saline solution for feces to be examined for Salmonella (including typhoid and paratyphoid) and Shigella (bacillary dysentery) and in cases of gastroenteritis (food poisoning).
11. THROAT CULTURE OUTFIT—for throat and nasal swabs for diphtheria, hemolytic streptococci, staphylococci, and other organisms.
12. BRUCELLA AND STREPTOCOCCUS BLOOD CULTURE OUTFITS—by special request.
13. GASTRIC OUTFIT—for the isolation of tubercle bacilli by culture.
14. WATER BACTERIOLOGY OUTFIT — sterile screw-capped bottles for purity, hardness, iron, and fluorine determinations of drinking water.
15. WATER CHEMISTRY OUTFIT—for domestic sewage, industrial effluents, stream and lake pollution, biological oxygen demand—sent only to State engineers or by special request.
16. PAPANICOLAOU SMEAR OUTFIT—containing instructions for collection of specimens submitted for detection of cancer.

Biologics Distributed

OLD TUBERCULIN—Request must include dilution desired and test dose to be used.

TYPHOID VACCINE.

STERILIZATION

The sterilization of individuals, for other than therapeutic reasons, is undoubtedly limited in Wisconsin to those cases specifically authorized by statute. An institutionalized criminal or mentally diseased person, under Sec. 46.12 Stats., may be sterilized provided that the elaborate precautions set forth in that statute are followed.

A physician who sterilizes a person for any but clearly therapeutic reasons may be guilty of performing an illegal operation. For that reason it is recommended that additional physicians be called in consultation to determine the therapeutic advisability of the procedure.

The illegal character of any but a therapeutic sterilization would not be altered because the patient or his representative consented in writing to the operation, or even requested it.

Officers of State Boards and Commissions

State Board of Health

Members of the Board

Stephen E. Gavin, M. D., President, Fond du Lac

Samuel L. Henke, M. D., Vice-President, Eau Claire

Carl N. Neupert, M. D., M.S.P.H., Secretary, Madison

William T. Clark, M. D., Janesville

Carl D. Neidhold, M. D., Appleton

Forrester Raine, M. D., Milwaukee

John S. Hollingsworth, D. D. S., Sheboygan

Bureaus, Divisions, and Units of State Board of Health

Carl N. Neupert, M. D., M.S.P.H., State Health Officer

E. H. Jorris, M. D., M.S.P.H., Assistant State Health Officer

Section on General Administration

E. H. Jorris, M. D., M.S.P.H., Director

Division of Staff Services—E. H. Jorris, M. D., M.S.P.H., Director

Division of Personnel—Henry Kjentvet, B.S., Director

Division of Statistical Services—Vivian B. Holland, M.S.P.H., Statistician

Division of Fiscal Services—Fred E. Brown, Ph. B., C.P.A., Director

Division of Internal Services—Lenore Brandon, Supervisor

Division of Laboratories—W. D. Stovall, M. D., Director

Bureau of Vital Statistics—Paul Weis, Assistant State Registrar

Division of Dental Education—Francis A. Bull, D. D. S., M.S.P.H., Director

Division of Health Education—Philip Dykstra, B. A., Director

Division of Hospital and Related Services—Vincent F. Otis, Director

Division of Cosmetology—Kathleen Bower, Supervisor

Division of Barbering—Thomas D. Ritchie, Supervisor

Division of Funeral Directing & Embalming—Helen Kjelson, Supervisor

Division of Hotels and Restaurants—Harold E. Olsen, Ph. B., Supervisor

Section on Preventable Diseases

Milton Feig, M. D., M. P. H., Director

Bureau of Communicable Diseases—Milton Feig, M. D., M. P. H., Director

Division of Tuberculosis Control—Milton Feig, M.D., Acting Director

Division of Venereal Disease Control—A. L. Van Duser, M. D., M. P. H., Director

Division of Cancer Control—A. L. Van Duser, M. D., M. P. H., Director

Division of Heart Disease Control—Milton Feig, M. D., Acting Director

Section on Environmental Sanitation

O. J. Muegge, M. S.—State Sanitary Engineer

Harvey Wirth, B. S.—Assistant State Sanitary Engineer

Bureau of Sanitary Engineering—Harvey Wirth, B. S., Director

Division of Plumbing—Walter Spencer, Supervisor

Division of Well Drilling—Thomas Calabresa, M. S., Supervisor

Division of Rendering and Slaughtering—Vacancy

Division of Water Pollution Control—T. F. Wisniewski, B. S., Director

Section on Maternal and Child Health

Amy Louise Hunter, M. D., Dr. P. H., Director

Bureau of Maternal and Child Health—Amy Louise Hunter, M. D., Dr. P. H., Director

Division of Child Guidance—Vacancy

Division of Nutrition—Lucile K. Billington, M. S., Supervisor

Section on Local Health Administration

Allan Filek, M. D., M. S. P. H., Director

Bureau of Public Health Nursing—Janet Jennings, R. N., M. A., Director

Division of Industrial Hygiene—William L. Lea, Ph. D., Director

Division of Local Health Administration—Allan Filek, M. D., M. S. P. H., Director

District Health Offices

No. 1—602 Insurance Building; Phone 6-4411, Extensions 2248 and 2249, Madison

No. 2—9 West Walworth, Phone 193, Elkhorn

No. 3—146 Forest Avenue; Phone 4055, Fond du Lac

No. 4—P. O. Box 251; 114½ South Water Street, Phone 566, Sparta

No. 5—City Hall, P. O. Box 270; Phone 685, Wisconsin Rapids

No. 6—1136 West Mason Street, Box 383; Phone Hemlock 2-1322, Green Bay

No. 7—417½ North Bridge Street; Phone 6642, Chippewa Falls

No. 8—City Hall; Phone 308-W, Rhinelander

State Board of Public Welfare

(Created by act of 1939 legislature to supplant the State Board of Control and combine certain other agencies; reorganized by act of 1949 legislature.)

Members of the Board

William H. Studley, M. D., Milwaukee, 1959
Mr. Harold W. Story, vice-chairman, Milwaukee, 1957
Mrs. Harrison L. Garner, Madison, 1959
Mr. Ralph Uihlein, Milwaukee, 1957
W. D. Stovall, M. D., chairman, Madison, 1955
Mrs. Karl Kleinpell, Cassville, 1955
Mr. Leo Jelinske, Shawano, 1955
Mr. Earl M. Hale, Eau Claire, 1959
Mrs. C. R. Beck, secretary, West Allis, 1957

Executive Staff

Mr. John W. Tramburg, Director
Mr. George M. Keith, Madison, Deputy Director

Division of Corrections
Mr. Russell G. Oswald, Madison, Director

Division of Mental Hygiene
Leslie A. Osborn, M. D., Madison, Director

Division of Public Assistance
Mr. Thomas J. Lucas, Sr., Madison, Director

Division of Business Management
Mr. Wilbur J. Schmidt, Madison, Director

Division for Children and Youth
Mr. Frederick DelliQuadri, Madison, Director

Basic Science Examiners

Prof. Michael F. Guyer, President, University of Wisconsin, 138 North Prospect Avenue, Madison 5, Wisconsin, 1955
Prof. W. H. Barber, Secretary, Ripon College, 621 Ransom Street, Ripon, Wisconsin, 1957
Prof. George G. Town, University of Wisconsin Extension Division, 623 W. State Street, Milwaukee, Wisconsin, 1959

State Board of Medical Examiners

J. W. Prentice, M. D., President, 522 West Second Street, Ashland, 1955
E. C. Murphy, D. O., 438 Gilbert Avenue, Eau Claire, 1957
Alvin G. Koehler, M. D., 46 Washington Boulevard, Oshkosh, 1955
Jerry W. McRoberts, M. D., 1011 North Eighth Street, Sheboygan, 1955
Clifford A. Olson, M. D., Baldwin, 1957
Thos. W. Tormey, Jr., M. D., Secretary, 1140 State Office Building, Madison, 1955
Millard Tufts, M. D., 208 East Wisconsin Avenue, 1957
John A. Schindler, M. D., 921 Sixteenth Avenue, Monroe, 1957

Wisconsin Industrial Commission

Members of the Commission

Mr. Voyta Wrabetz, Chairman, 1955
Mr. R. G. Knutson, 1957
Mr. A. W. Enright, 1959
Miss Helen E. Gill, Secretary

Workmen's Compensation Department
Mr. Harry A. Nelson, Director

Unemployment Compensation Department
Mr. Paul R. Raushenbush, Director

Safety and Sanitation Department
Mr. O. T. Nelson, Director

Woman and Child Labor Department
Maud Swett, Director

State Board of Vocational and Adult Education

E. J. Fransway, Employee member_____Wauwatosa
Mrs. Erna Cartwright, Employee member__Oshkosh
Frank C. Horyza, Employee member_____Superior
Alfred A. Laun, Employer member_____Kiel
Robert L. Pierce, Employer member_____Menomonie
Morton Frost, Employer member_____Kenosha
John Last, Farmer member_____Lake Mills
T. E. Hamilton, Farmer member_____Westfield
Elmer Wilkins, Farmer member_____Platteville
G. E. Watson, ex officio_____Madison
Voyta Wrabetz, ex officio_____Madison
C. L. Greiber, ex officio_____Madison
State Director, State Board of Vocational and Adult Education

Rehabilitation Division

State Office

Room 320, State Office Building, Madison

John A. Kubiak_____Chief
J. H. Brown_____Assistant Chief
Charles Beardsley
_____Guidance, Training and Placement
Irene M. Dunn_Finances and Mentally Handicapped
A. E. Towne_____Medical Service
Mrs. Mary F. Beyer_____Homecraft
Edward J. Pfeifer_____Psychological Service
Milton Feig, M. D.
_____Medical Administrative Consultant (part time)
Mrs. Inez F. Belyea_____Medical Social Worker
Mrs. Thelma Peckham_____Statistician

District Offices

Madison_____Vocational School Building, 211 North Carroll Street, Room 458
C. D. Rejahl, District Supervisor

Milwaukee Vocational School Building, 1015 North Sixth Street, Room 222
L. A. Rumsey, District Supervisor

Green Bay Vocational School Building, 200 South Broadway
A. W. Bouffard, District Supervisor
Eau Claire 8½ South Farwell Street
Melvin J. Chada, District Supervisor

Local Offices

La Crosse Vocational School Building
Carl J. Haase, Case Supervisor
Racine 828 Center Street
V. C. Bryan, Case Supervisor

Wausau Vocational School Building
L. J. Schultz, Case Supervisor
Superior 917 Tower Avenue
H. C. Ritzman, Case Supervisor

DIVISION ON REHABILITATION OF COMMISSION ON STATE DEPARTMENTS

R. G. Piaskoski, M. D. Milwaukee
P. J. Collopy, M. D. Milwaukee
E. P. Roemer, M. D. Madison
J. G. Beck, M. D. Sturgeon Bay
C. C. Gascoigne, M. D. Kohler

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1954, the March of Medicine began its ninth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 40 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WATK	Antigo	Saturday	8:45 a.m.
WHBY	Appleton	Saturday	8:30 a.m.
WATW	Ashland	Saturday	8:15 a.m.
WHSA	Brule	Saturday	1:15 p.m.
WHKW	Chilton	Saturday	1:15 p.m.
WCHF	Chippewa Falls	Saturday	9:00 a.m.
WHWC	Colfax	Saturday	1:15 p.m.
WHAD	Delafield	Saturday	1:15 p.m.
WEAU	Eau Claire	Saturday	11:45 a.m.
KFIZ	Fond du Lac	Saturday	5:30 p.m.
WBAY	Green Bay	Saturday	3:15 p.m.
WHHI	Highland	Saturday	1:15 p.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	9:30 a.m.
WHA	Madison	Saturday	1:15 p.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Saturday	11:45 a.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	10:15 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WIBU	Poynette	Thursday	2:45 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	5:45 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WRDB	Reedsburg	Tuesday	9:30 a.m.
WOBT	Rhinelander	Saturday	10:30 a.m.
WHRM	Rib Mountain	Saturday	1:15 p.m.
WJMC	Rice Lake	Saturday	9:45 a.m.
WRCO	Richland Center	Wednesday	3:30 p.m.
WTCH	Shawano	Sunday	6:45 p.m.
WHBL	Sheboygan	Tuesday	7:15 p.m.
WLBL	Stevens Point	Saturday	1:15 p.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m
WDSM	Superior	Sunday	9:00 p.m.
WTTN	Watertown	Tuesday	11:30 a.m.
WSAU	Wausau	Saturday	9:15 a.m.
WBKV	West Bend	Saturday	11:30 a.m.
WHLA	West Salem	Saturday	1:15 p.m.

Rehabilitation Services in Wisconsin

REHABILITATION services are available to eligible persons in Wisconsin through a program operated under the Rehabilitation Division of the State Board of Vocational and Adult Education. The program consists of special assistance to citizens who, because of physical or mental impairment, would either remain unemployable or would be employed at marginal pursuits.

Any person of working age is eligible for any necessary physical restoration services if he meets the following requirements:

1. He has a physical or mental defect which is a substantial employment handicap.
2. It is static, stationary, stable, or only slowly progressive. (Thus, acute illnesses and emergency cases are excluded.)
3. The disability can be removed or substantially reduced by treatment in a reasonable length of time.
4. He is unable to pay the full cost of the services out of his own resources.
5. The necessary services are not available from any other source.

Where eligibility and economic need are established, the following services can be provided: medical, psychiatric, and surgical examinations and treatment; hospitalization; convalescent care; dental care; nursing care; physical therapy; occupational therapy; speech therapy; prosthetic appliances; medical supplies; and drugs. Each applicant for vocational rehabilitation services is required to have a thorough medical examination before any services are provided. This examination usually is performed by his family physician and is financed by the state agency. In Wisconsin a committee of physicians advises the state agency regarding such matters of policy as professional standards, fee schedules, etc.

In providing service the Rehabilitation Division utilizes such public and private facilities as are available. In the medical area the Curative Workshops of Milwaukee, Green Bay, and Racine provide occupational and physical therapy, speech training, and other services. These workshops provide services on an outpatient basis only.

All patients are referred to the centers by the attending physician and are discharged by him upon completion of treatment. Physicians receive progress reports. Professional policies and practices are determined by medical advisory committees of the local medical societies.

The addresses of the workshops are as follows:

Curative Workshop of Green Bay, 1001 Cherry Street, Green Bay, Wisconsin.

Curative Workshop of Milwaukee, 750 North 18th Street, Milwaukee, Wisconsin.

Curative Workshop of Racine, 233 Northwestern, Racine, Wisconsin.

The only rehabilitation center in Wisconsin providing both inpatient and outpatient services is located in Madison and offers the following services:

Wisconsin Neurological Foundation, Madison

This is a 45-bed unit with private, semiprivate, and ward rooms. There are facilities available for complete diagnostic and therapeutic management of neurologic patients; a department of physical medicine; facilities for psychologic testing, vocational counseling, occupational therapy, and recreation. The service is operated by physicians and dentists with an adequately trained staff.

Physicians interested in making these services available to their patients may contact the facilities directly or through the Vocational Rehabilitation Office nearest them. Rehabilitation service is offered through the Rehabilitation Division of the State Board of Vocational and Adult Education only to persons of employable age who meet the criteria outlined above. Following is a list of district and local offices, with the name and title of the person in charge:

District 1

Madison 3—Vocational School Building, 211 North Carroll Street, Room 458. Clare D. Rejahl, District Supervisor

Local Offices:

La Crosse—Vocational School—Carl J. Haase, Case Supervisor

Racine—828 Center Street—Virgil C. Bryan, Case Supervisor

District 2

Milwaukee 3—Vocational School Building, 1015 North Sixth Street, Room 222. Leslie A. Rumsey, District Supervisor

District 3

Green Bay—Vocational School Building, 200 South Broadway. Arthur W. Bouffard, District Supervisor

Local Office:

Wausau—Vocational School Building, Box 750—Levern J. Schultz, Case Supervisor

District 4

Eau Claire—8½ South Farwell Street. Melvin J. Chada, District Supervisor

Local Office:

Superior—917 Tower Avenue, Room 11—Herbert C. Ritzman, Case Supervisor

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, by-laws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

(3) (a) The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(b) Such plan shall be exempt from the state insurance laws except those provisions relating to nondiscriminatory rates contained in section 201.53, investments contained in section 201.25 and premium reserves contained in section 201.18 (1).

(c) The society shall file with the commissioner of insurance a written declaration defining the organization and structure of the proposed sickness care plan and its area of operations and shall file any amendments or changes thereto. There shall also be filed with the commissioner specimen copies of all contracts with the insured and with the participating physicians and surgeons and the form of such contracts must be approved by the commissioner.

(d) The provisions of section 148.01 (3) (c) shall not apply to any plan nor to any revisions thereof in existence on the effective date of this paragraph, nor to any contracts for the care of the indigent, nor shall any provision of chapter 148 be construed to apply to any corporation, association or organization not a body corporate under said chapter.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, by-laws and regulations of the state society.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

The State Medical Society of Wisconsin

1955 Officers and Councilors

President

Dr. A. J. McCarey
305 East Walnut Street
Green Bay

President-Elect

Dr. E. L. Bernhart
2714 West Burleigh Street
Milwaukee

Secretary

Mr. C. H. Crownhart
704 East Gorham Street
Madison 3

Assistant Secretaries

Mr. Roy T. Ragatz
704 East Gorham Street
Madison 3
Mr. Earl R. Thayer
704 East Gorham Street
Madison 3

Treasurer

Dr. F. L. Weston
1 South Pinckney
Madison

Speaker, House of Delegates

Dr. L. O. Simenstad
Osceola

Councilors*

(Dr. R. G. Arveson, Frederic, Chairman)

First: Dodge, Jefferson and Waukesha County Societies. Dr. W. D. James, Oconomowoc, 1957.

Second: Kenosha, Racine and Walworth County Societies. Dr. L. H. Lokvam, 723 58th Street, Kenosha, 1957.

Third: Dane, Columbia-Marquette-Adams, Green, Rock and Sauk County Societies. Dr. N. A. Hill, 304 West Washington Avenue, Madison 1955; Dr. H. E. Kasten, 419 Pleasant Street, Beloit, 1957.

Fourth: Crawford, Grant, Iowa, Lafayette and Richland County Societies. Dr. E. M. Dessloch, Prairie du Chien, 1955.

Fifth: Calumet, Manitowoc, Sheboygan and Washington-Ozaukee County Societies. Dr. A. H. Heidner, West Bend, 1955.

Sixth: Brown-Kewaunee-Door, Fond du Lac, Outagamie and Winnebago County Societies. Dr. A. J. McCarey, 305 East Walnut Street, Green Bay, 1955.

Seventh: Juneau, La Crosse, Monroe, Trempealeau-Jackson-Buffalo and Vernon County Societies. Dr. J. C. Fox, 508 Batavia Bank Building, La Crosse, 1956.

Eighth: Marinette-Florence, Oconto and Shawano County Societies. Dr. J. M. Bell, Marinette, 1956.

Ninth: Clark, Green Lake-Waushara, Lincoln, Marathon, Portage, Waupaca and Wood County Societies. Dr. R. E. Garrison, Wisconsin Rapids, 1956.

Tenth: Barron-Washburn-Sawyer-Burnett, Chippewa, Eau Claire-Dunn-Pepin, Pierce-St. Croix, Polk and Rusk County Societies. Dr. R. G. Arveson (chairman), Frederic, 1956.

Eleventh: Ashland-Bayfield-Iron and Douglas County Societies. Dr. V. E. Ekblad, 1507 Tower Avenue, Superior, 1957.

Twelfth: The Medical Society of Milwaukee County. Dr. R. E. Galasinski, 1227 West Lincoln Avenue, Milwaukee; Dr. E. L. Bernhart, 2714 West Burleigh Street, Milwaukee; Dr. N. J. Wegmann, 2510 West Capitol Drive, Milwaukee, 1957; Dr. W. T. Casper, 2218 North Third Street, Milwaukee, 1955.

Thirteenth: Forest, Langlade, Oneida-Vilas and Price-Taylor County Societies. Dr. C. E. Zellmer, Antigo, 1956.

Dr. H. Kent Tenney, 1 South Pinckney Street, Madison.

Dr. S. E. Gavin, 104 South Main Street, Fond du Lac, Chairman Emeritus.

Delegates to American Medical Association

Dr. S. E. Gavin (1956)
104 South Main Street
Fond du Lac

Dr. W. D. Stovall (1955)
State Laboratory of Hygiene
Madison

Dr. D. H. Witte (1956)
3300 West Wisconsin Avenue
Milwaukee

Alternates

Dr. L. O. Simenstad (1956)
Osceola

Dr. Joseph C. Griffith (1956)
944 North Jackson Street
Milwaukee

Dr. G. E. Forkin (1955)
Menasha

* Map indicating location of councilor districts, page 115.

Standing Committees—1954-1955

Committee on Cancer

R. P. Welbourne, M.D., chairman, 1957, 113 North Third Street, Watertown

A. R. Curreri, M.D., 1955, 1300 University Avenue, Madison

W. S. Bump, M.D., 1956, 1020 Kabel Avenue, Rhinelander

James E. Conley, M.D., 1956, 425 East Wisconsin Avenue, Milwaukee

J. W. Conklin, M.D., 1956, Platteville

A. C. Taylor, M.D., 1957, 103 West College Avenue, Appleton

P. B. Blanchard, M.D., 1957, Cedarburg

Conrad W. Giesen, M.D., 1957, 1514 Ogden Avenue, Superior

K. G. Pinegar, M.D., 1955, 1723 Main Street, Marinette

R. B. Larsen, M.D., 1955, 510 Third Street, Wausau

G. I. Uhrich, M.D., 1956, 319 Main Street, La Crosse

Lucille Radke, M.D., 1956, 307 East La Salle Avenue, Barron

R. J. Schacht, M.D., 1956, 1704 Milwaukee Avenue, Racine

Committee on Grievances

R. E. Fitzgerald, M.D., 1957, chairman, 2218 North Third Street, Milwaukee 12

E. W. Mason, M.D., 1956, 324 East Wisconsin Avenue, Milwaukee 2

E. D. Sorenson, M.D., 1956, Elkhorn

C. E. Zellmer, M.D., 1957, Antigo

F. A. Nause, M.D., 1955, 927–A North Eighth Street, Sheboygan

H. W. Wirka, M.D., 1955, 1300 University Avenue, Madison

C. D. Neidhold, M.D., 1957, 103 West College Avenue, Appleton

C. B. Hatleberg, M.D., 1955, 206 Bridge Street, Chippewa Falls

J. L. Moffett, M.D., 1956, 107 East Main Street, Platteville

Committee on Hospital Relations

A. H. Barr, M.D., 1957, chairman, 214 North Wisconsin Street, Port Washington

S. R. Beatty, M.D., 1957, 117 North Commercial Street, Neenah

W. B. Hildebrand, M.D., 1955, 216½ Main Street, Menasha

O. V. Overton, M.D., 1955, 58 South Main Street, Janesville

W. R. Kreul, M.D., 1956, 100 Twelfth Street, Racine

R. S. Haukohl, M.D., 1956, 1821 West Wisconsin Avenue, Milwaukee

Committee on Medical Education and Hospitals

T. L. Squier, M.D., 1956, 425 East Wisconsin Avenue, Milwaukee 2

N. M. Clausen, M.D., 1958, 2 West Gorham Street, Madison 3

I. E. Schiek, Jr., M.D., 1959, 114 West Davenport Street, Rhinelander.

J. W. Boren, Jr., M.D., 1955, 1510 Main Street, Marinette

A. P. Zlatnik, M.D., 1957, 1421 Seventeenth Street, Two Rivers

W. S. Middleton, M.D., ex officio, 1300 University Avenue, Madison 6

J. S. Hirschboeck, M.D., ex officio, 561 North Fifteenth Street, Milwaukee 3

Committee on Coordination of Medical Services

J. F. Wilkinson, M.D., 1957, chairman, 114 East Wisconsin Avenue, Oconomowoc

J. W. Nellen, M.D., 1959, 504 Bellin Building, Green Bay

T. W. Tormey, M.D., 1955, 16 North Carroll Street, Madison 3

S. E. Gavin, M.D., 1956, 104 South Main Street, Fond du Lac

R. B. Larsen, M.D., 1958, 510 Third Street, Wausau

President, ex officio

Secretary, ex officio

Council on Medical Services

D. E. Dorchester, M.D., 1957, chairman, 10 North Third Avenue, Sturgeon Bay

T. D. Elbe, M.D., 1956, Thiensville

J. F. Maser, M.D., 1956, Rice Lake

D. N. Goldstein, M.D., 1956, 625 Fifty-Seventh Street, Kenosha

R. L. MacCornack, M.D., 1957, Whitehall

H. J. Kief, M.D., 1957, 104 South Main Street, Fond du Lac

D. M. Willison, M.D., 1955, 314 East Grand Avenue, Eau Claire

J. S. Devitt, M.D., 1955, 944 North Jackson Street, Milwaukee 2

W. J. Fencil, M.D., 1955, The Monroe Clinic, Monroe

Committee on Public Policy

J. M. Sullivan, M.D., 1957, chairman, 161 West Wisconsin Avenue, Milwaukee

J. R. Schroder, M.D., 1958, 500 West Milwaukee Street, Janesville

J. P. Conway, M.D., 1959, 1800 E. Capitol Drive, Milwaukee

S. E. Gavin, M.D., 1955, 104 South Main Street, Fond du Lac

J. K. Curtis, M.D., 1956, 2500 Overlook Terrace, Madison

President, ex officio

President-elect, ex officio

Secretary, ex officio

Council on Scientific Work

P. A. Midelfart, M.D., chairman, 1955, 314 East Grand Avenue, Eau Claire

S. A. Morton, M.D., 1956, 3321 North Maryland Avenue, Milwaukee 11

M. G. Rice, M.D., 1957, 401 Main Street, Stevens Point

L. G. Kindschi, M.D., 1958, The Monroe Clinic, Monroe

K. E. Lemmer, M.D., 1959, 1300 University Avenue, Madison

R. S. Baldwin, M.D., ex officio, 650 South Central Avenue, Marshfield

J. S. Hirschboeck, M.D., ex officio, 561 North Fifteenth Street, Milwaukee 3

W. S. Middleton, M.D., ex officio, 1300 University Avenue, Madison 6

Special Committee of the President on Veteran Affairs

F. L. Weston, M.D., 1 South Pinckney, Madison 3, chairman

J. P. Conway, M.D., 1800 East Capitol Drive, Milwaukee 11

S. W. Hollenbeck, M.D., 2650 West Fond du Lac Avenue, Milwaukee 6

C. E. Koepp, M.D., Marinette Medical Clinic, Marinette

F. H. Wolf, M.D., 419–421 Main Street, La Crosse

R. E. Galasinski, M.D., 3333 South 27th Street, Milwaukee, ex officio

President, ex officio

President-elect, ex officio

Council Committees

The following committees are committees of the Council. Appointments are made by the chairman of the Council following its annual meeting in February, and names of committee members are published in the March issue of the *Journal.*

Advertising
Audit and Budget
Blood Bank
Civil Defense
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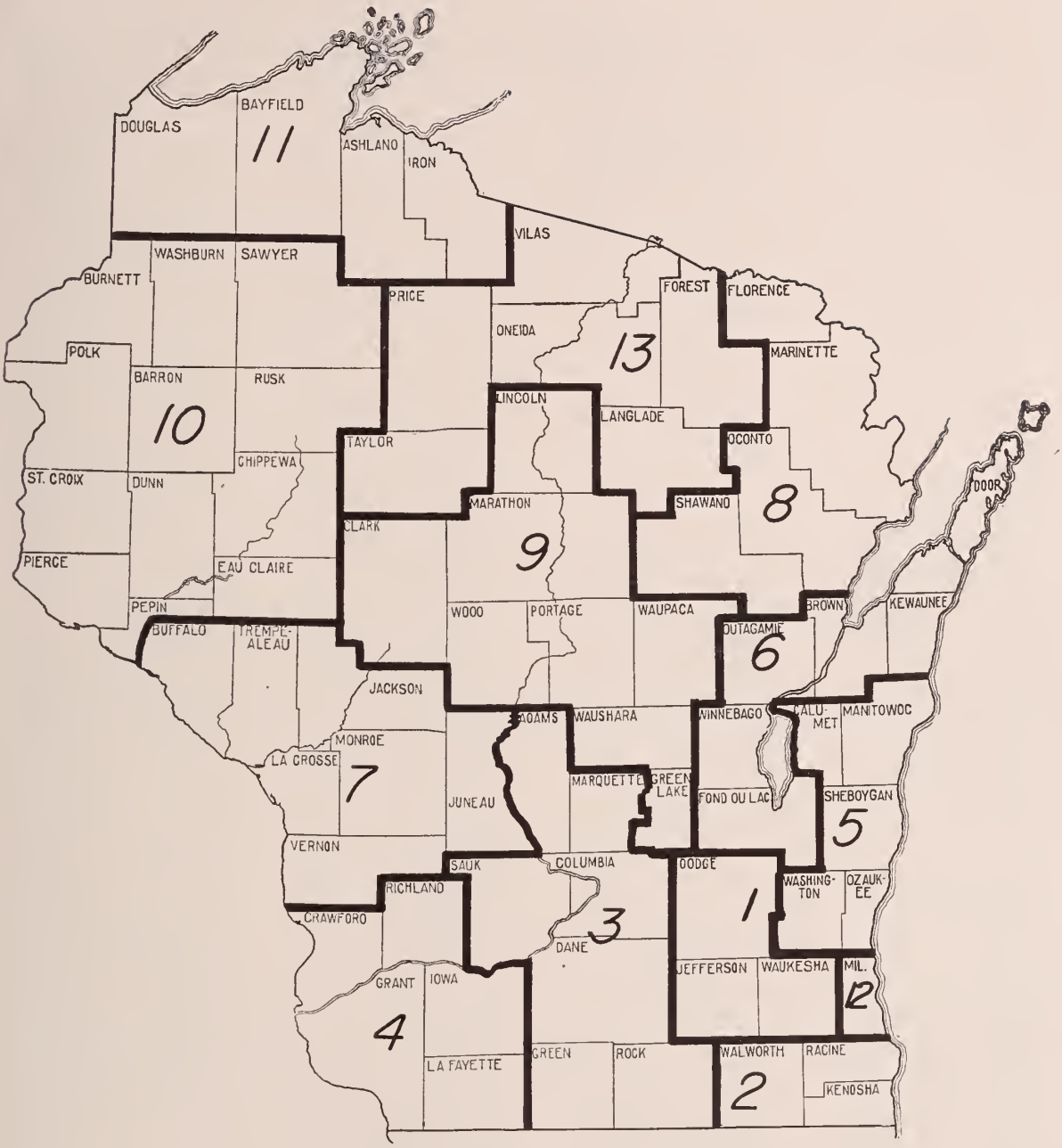

MAP INDICATING LOCATION OF COUNCILOR DISTRICTS

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Dr. W. D. James, Oconomowoc

Second District:
Dr. L. H. Lokvam, Kenosha

Third District:
Dr. N. A. Hill, Madison
Dr. H. E. Kasten, Beloit

Fourth District:
Dr. E. M. Dessloch, Prairie du Chien

Fifth District:
Dr. A. H. Heidner, West Bend

Sixth District:
Dr. A. J. McCarey, Green Bay

Seventh District:
Dr. J. C. Fox, La Crosse

Eighth District:
Dr. J. M. Bell, Marinette

Ninth District:
Dr. R. E. Garrison, Wisconsin Rapids

Tenth District:
Dr. R. G. Arveson, Chairman, Frederic

Eleventh District:
Dr. V. E. Ekblad, Superior

Twelfth District:
Dr. R. E. Galasinski, Milwaukee
Dr. E. L. Bernhart, Milwaukee
Dr. N. J. Wegmann. Milwaukee
Dr. W. T. Casper, Milwaukee

Thirteenth District:
Dr. C. E. Zellmer, Antigo

Dr. S. E. Gavin, Chairman Emeritus, Fond du Lac

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Ingersoll, R. S.

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Naylen, F. J.

Albany:
Bongiorno, F. J.

Algoma:
March, J. F.
Pudleiner, H. G.
Stiehl, C. W.

Allenton:
Fisher, R. S.

Alma:
Bachhuber, M. O.

Amery:
Cornwall, W. B.
Dasler, H. A.
Ford, K. K.
Kremser, V. C.
Marra, M. G.
Whitlark, F. L.

Amherst:
Osicka, S. R.

Antigo:
Bloor, E. G.
Curran, W. P.
Donohue, M. J.
Dorzeski, E. F.
Garbisch, F. H.
Lambert, J. W.
McKenna, E. A.
Moore, G. E.
Zellmer, C. E.

Appleton:
Adrians, W. A.
Benton, J. L.
Bolton, E. L.
Carlson, G. W.
Cunningham, P. M.
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DeCock, R. D.
Dehne, W. O.
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French, G. A.
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Gross, H. T.
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Hegner, G. T.
Huberty, F. J.
Kagen, M. S.
Konz, S. A.
Krueger, E. N.
Laird, J. W.
Landis, R. V.
MacLaren, J. B.
Marshall, F. S.
Marshall, V. F.
McBain, L. B.
Mielke, E. F.
Neidhold, C. D.
Rankin, F. J.
Russell, J. H.
Siegrist, K. J.
Simenson, R. S.
Skibba, J. P.
Swanton, M. E.
Taylor, A. C.
Williams, L. P.
Wright, Frank, Jr.
Young, J. J.
Zeiss, E. J.

Arcadia:
Comstock, Elizabeth
Dockendorff, B. C.
Weber, F. T.

Arpin:
Ryan, C. J.

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Butler, Albert
Grand, C. A.
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Harrison, G. W.
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Krener, J. E.
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Prentice, B. C.
Prentice, J. W.
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Smiles, C. J.
Smiles, W. J.
Tucker, W. J.
Weeks, F. D.

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Avoca:
Reynolds, Bertha

Augusta:
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Thieda, E. S.

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Fauley, G. B.
Fillbach, H. E.

Baldwin:
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Sargeant, G. M.

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Burdette, Stella I.

Bangor:
Ruppenthal, K. P.

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Huth, M. F.
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Strang, C. J.
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Moody, L. W.

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Morneau, L. F.

Beaver Dam:
Bayley, H. G.
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Bergen, P. M.
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Costello, W. H.
Davis, T. C.
Drescher, G. G.
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Petersen, G. J.
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Urbanek, R. E.
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Way, R. W.
Webb, E. P.
Welsch, J. M.

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Turgeson, J. F.

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Allen, W. J.
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Brillman, L. P.
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Carter, K. L.
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Clark, D. M.
Cochrane, W. L.
Crockett, W. W.
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Fitzgerald, W. M.
Flarity, T. H.
Fosse, Benjamin
Freeman, W. S.
Friend, L. J.
Glesne, O. G.
Gunderson, R. H.
Helm, H. M.
John, G. W.
Johnson, F. K.
Jones, E. T.
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Kishpaugh, H. W.
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McGaughey, C. G.
Ottow, A. F.
Peterson, G. H.
Pollard, W. H., Jr.
Pranke, D. W.
Raube, H. A.
Rechlitz, E. T.
Sanderson, R. J.
Shearer, H. A.
Springberg, J. C.
Thayer, R. A.
Thomson, G. H.
Twyman, A. H.
Vivian, R. S.
Wilson, R. F.

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Koch, H. C.
Seward, L. J.
Sievers, D. J.
Stone, G. C.
Taugher, V. J.
Wiesender, A. J.

Big Bend:
Boldt, R. E.
Raschbacher, J. L.

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Damp, O. E.

Black River Falls:
Krohn, Robert
Marks, J. R.
Noble, J. H.

Blair:
Schneider, O. M.

Blanchardville:
Unterholzner, L. J.

Bloomer:
Clauson, C. T.
Hudek, D. F.
Murphy, P. W.

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Cusick, W. S.
Edwards, P. K.

Bonduel:
Terlinden, J. H.

Boscobel:
Freymiller, E. F.
Hayman, C. S.
McNamee, J. R.
Randall, E. M.
Randall, M. W.

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Lautenbach, E. T.

Brillion:
Guthrie, J. M.
Langmack, W. A.

Brodhead:
Stovall, W. D., Jr.
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Brownsville:
Friedrich, L. E.
Raymond, R. G.
Ries, M. F.

Bruce:
Whalen, M. L.

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Baker, D. J.
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Carroll, J. H.
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Granzeau, H. W.
Mastalir, L. O.
Newell, F. F.
Sroka, Wm. C.
Van Liere, J. D.

Butler:
Schoeneman, R. H.

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Zenner, C. E.

Cambria:
Brown, J. G.

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Amundson, K. K.
Bilstad, G. E

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Cronk, C. F.

Campbellsport:
Guenther, O. F.
Hoffmann, L. A.

Casco:
Kerscher, E. J.

Cashton:
Mauel, N. M.

Cassville:
David, J. J.

Cedarburg:
Blanchard, P. B.
Evenson, R. G.
Hurth, O. W.
Katz, H. J.

Cedar Grove:
Jensen, J. S.

Chetek:
Adams, R. W.

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Goggins, J. W.
Humke, E. W
Humke, K. R.
Knauf, N. J.
Minahan, J. J.

* As of December 15, 1954

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Henske, W. C.
Janc, W. F.
Kelly, J. A.
Kemper, C. A.
McHugh, F. T.
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Sazama, J. J.
Smith, Thorsten

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Larson, Owen E.
Miller, E. A.
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Hansen, R. L.
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Lund, R. E.
Lund, S O.
Thompson, R. C.

Dallas:
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Truex, G. O.

Darlington:
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McGreane, N. A.
Oertley, Robert E.
Olson, Lyle L.

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De Forest:
Grinde, J. M.

Delafield:
Olsen, L. C. J.

Delavan:
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Michna, C. T.

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Walker, H. M.

Dorchester:
Foley, F. P.

Dousman:
Notbohm, W. R.
Watry, T. D.

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Bryant, R. J.

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Burnett, C. H.
Colgan, J. J.
Oldfield, R. A. A.

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Kohn, Louis

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Finucane, P. J.
Frank, R. C.
Fuson, H. S.
Gericke, J. T., Jr.
German, K. L.
Haag, A. F.
Hayes, E. P.
Henke, S. L.
Hilker, A. W.
Hoff, D. E.
Huston, H. C.
Ihle, C. M.
Kennedy, R. L.
Kinsman, F. C.
Klein, A. J.
Lorenz, A. A.
Lotz, R. M.
Lowe, J. W.
Manz, W. R.
Mason, E. L.
Mautz, W. T.
McAffee, G. D.
Midelfart, Peter
Nester, H. D.
Nezworski, L. G.
Parrish, J. G., Jr.
Paulson, W. O.
Richards, R. R.
Russell, S. B.
Sorensen, H. E.
Spelbring, P. G.
Stewart, Katherine
Strand, R. C.
Wahl, G. E.
Walter, K. E.
Willison, D. M.
Wishart, J. H.
Ziegler, J. E. B.

Edgar:
Schulz, H. A.

Edgerton:
Burpee, G. F.
Cohen, D. A.
Falk, V. S., Jr.
Shearer, A. T.
Shearer, F. E.
Sumner, W C.
Vanstane, V. R.

Elcho:
Dailey, D. W.
Dailey, P. J.

Eleva:
Martins, J. K.

Elkhart Lake:
Martineau, J. E.

Elkhorn:
Bill, K. C.
Hatfield, Margaret E.
Helmbrecht, M. G.
Rawlins, J. A.
Sorenson, E. D.
Young, J. H.

Ellsworth:
Aanes, A. R.

Elm Grove:
Grade, J. O.
Redlin, R. R.
Schmidt, E. A.
Zurheide, H. J.
Zurheide, H. J. O.

Elmwood:
Springer, F. A.
Springer, J. P.

Elroy:
Curtis, W. E.
Demke, R. L.

Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Gray, Roger S.
Sorkin, S. S.

Fall Creek:
Zboralske, F. F.

Fennimore:
Bailey, M. A.
Howell, E. C.
Shields, C. H., Jr.

Fond du Lac:
Becker, N. O.
Borsack, K. K.
Cerny, F. J
Coyne, John F.
Devine, H. A.
Devine, J. C.
Flanagan, C. M.
Folsom, W. H.
Fransway, R. L.
Gardner, L. C.
Gavin, S. E.
Guth, H. K.
Huebner, J. S.
Hutter, A. M.
Keenan, L. J.
Kendell, W. G.
Kief, H. J.
Leonard, C. W.
Mauthe, Howard
McCabe, L. B.
McCormick, D. W.
McCullough, James C.
McCullough, John C.
McLane, Hugh J.
Myers, W. E.
Pallin, Josephine J.
Pawsat, E. H.
Peterson, C. R.
Sharpe, H. R.
Sharpe, H. R., Jr.
Sharpe, J. J.
Smith, D. A.
Smith, E. V., Jr.
Steube, R. W.
Swan, J. C.
Theisen, S. A.
Twohig, D. J.
Twohig, D. J., Jr.
Vetter, E. W.
Waffle, R. L.
Waldschmidt, W. J.
Wier, J. S.
Willson, D. D.
Wojta, W. C.
Yockey, J. C.

Footville:
Harvey, J. R.

Forestville:
Hirschboeck, J. G.

Ft. Atkinson:
Gruesen, F. A.
Gueldner, L. H.
Hanson, O. H.
Harris, J. J.
Hunsader, H. N.
Lyons, R. P.
Mallow, H. G. E.
Notbohm, D. R.
Russell, J. C. H.
Venning, J. R.
Young, Will

Fountain City:
Skemp, F. C.

Fox Lake:
Elliott, E. S.

Frederic:
Andrews, W. C.
Arveson, R. G.
Fischer, W. A.
Moore, R. M.

Fremont:
Arnoldussen, C. P.

Friendship:
Treadwell, G F.

Galesville:
Alvarez, R. L.
Moen, C. B.
Rohde, E. P.

Gays Mills:
Boyce, S. R.
Schott, O. J.

Genoa City:
McNeel, Laird

Gillett:
Bailey, D. M.

Gilman:
McLane, Wm. L.

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Limberg, P. W.
McCusker, C. F.

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Ansfield, F. J.

Gordon:
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Grafton:
Pelant, K. F.

Grantsburg:
Hartzell, R. L.
Larson, H. H.

Green Bay:
Austin, S. D.
Blackburn, M. D., Jr.
Boersma, J. J.
Bolles, C. S.
Breckenridge, H. E.
Brusky, A. H.
Brusky, E. S.
Burdon, T. S.
Clark, E. V., Jr.
Cowles, R. L.
Crawford, C. W.
Daley, E. F.
Danaher, H. H.
Denys, G. F.
Denys, K. J.
Dettmann, J. E.
Dockry, P F
Edelblute, L. H.
Ford, J. L.
Ford, W. W.
Freedman, A. L.
Fuller, M. H.
Goelz, J. R.
Gosin, F. J.
Gosin, Robert F.
Griggs, S. L.
Grossman, M. A.
Hagerty, W. T.
Halloin, J. E.
Heltzman, H. H.
Hipps, C. J.
Hitch, O. M.
Icks, K. R
Jensen, R. E.
Jordan, E. M.
Kane, Elizabeth D.
Kaufman, J. E.
Killeen, E. R
Killins, J. A.
Killins, W. A.
Kispert, R. W
Kuehl, F. O.
Kuhs, M. L.
Kulkoski, Bernard
Leaper, W. E.
Levitas, I. E.
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McDermott, J. F.
McGuire, G. E.
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Miller, L. C.
Milson, Louis
Mokrohisky, S. M.
Nadeau, E. G.
Nadeau, E. George, Jr.
Nellen, J. W.
Neu, V F.
Olson, R. C.
Paine, E. M.
Quigley, L. D.
Robb, J. J.
Rose, R. J
Rothe, C. A., Jr.
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Schmidt, E. S.
Schmidt, R. T.
Shinners, G. M.
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Stiennon, O. A.
Sullivan, Donel
Tippet, W. P.
Troup, R. L.
Troup, W. J.
Urban, Frank
Warpinski, M. A.
Wochos, R. G.
Wunsch, C. A.

Green Lake:
Leininger, A. T.

Greendale:
Brown, R. J.
Curtin, J. J.

Greenwood:
Olson, W. A.

Gresham:
Litzen, F. L.

Hales Corners:
Larsen, L. L.
Pierce, D. F.
Wolf, R. C.

Hartford:
Hoffmann, J. G.
Hoffmann, W. C. P.
Kern, T. J.
Lehmann, F. W.
Monroe, M. E.
Quackenbush, E. O.
Quandt, V. V.
Sachse, F. W.

Hartland:
Hansen, R. T.
Howlett, J. R.
Ridley, J. F.

Hawthorne:
Sandell, S. T.

Hayward:
Callaghan, D. H.
Krueger, E. R.
Wyant, M. E.

Hazel Green:
Althaus, C. F.
Rosmann, H. K.
Strauch, C. B.

Highland:
Erickson, M. T.

Hilbert:
Winkler, R. J.

Hillsboro:
Leuther, P. A.
Sanford, L. L.

Hollandale:
Marshall, S. B.

Horicon:
Karsten, J. H.
Knudson, R. A.

Hortonville:
Flanagan, F. J.
Towne, W. H.

Hudson:
Anderson, M. G.
Bourget, G. E.
Hopkins, G. J.
Livingstone, J. W.
Newton, J. E.

Hurley:
Bonacci, M. J.
Martinetti, D. J.

Hustisford:
Goetsch, O. F.

Independence:
Peterson, D. R.

Iola:
Wiley, R. H.

Jackson:
Albrecht, J. E.
Evans, H. C.

Janesville:
Bartels, G. W.
Baumgartner, M. M
Betlach, Dorothy W.
Betlach, Eugene H.
Clark, W. T.
Danforth, H. C.
Dodge, R. K.
Donkle, M. J.
Farnsworth, R. W.
Fitzgerald, G. P.
Frechette, F. M.
Freitag, S. A.
Gilbertsen, C. R.
Gredler, Gerald P.
Gutmann, G. E.
Hartlaub, E. S.
Johnson, W. L.
Kelley, J. F.
Klein, T. W.
Koch, V. W.
Llewellyn, M. B.
McGuire, W. H.
Metcalf, G. S.
Nuzum, T. O.
Odland, P. K.
Otterholt, E. R.
Overton, O. V.
Overton, R. S.
Pember, A. H.
Pember, J. F.
Purdy, M. F.
Rau, Esther L.
Reinardy, A. L.
Reinardy, E. W.
Schroder, John R.
Schroeder, Jack D.
Snodgrass, H. M.
Snodgrass, T. J.
Steinkopff, E. K.
Tarrasch, Hertha
Thomas, G. L.
Tomlinson, Carol
Tordoff, J. J.
Welch, F. B.

Jefferson:
Brewer, J. C.
Busse, A. A.
Caswell, H. O.
Garding, C. J.
Quandt, C. E.
Quandt, R. W.
Robinson, A. H.

Johnson Creek:
Wendt, F. A.

Junction City:
Reis, G. W.

Juneau:
Ferguson, E. C.
Heath, H. J.

Kaukauna:
Bachhuber, A. E.
Bachhuber, A. M.
Behnke, G. A.
Boyd, G. L.
Cherkasky, Simon
Flanagan, G. J.
Russo, J. G.

Kendall:
Curtis, W. E.

Kenosha:
Altman, J. S.
Ambro, P. J.
Andre, E. F.
Ashley, R. W.
Bertolaet, E. E.
Binnie, Helen A.
Bjork, H. A.
Block, R. M.
Bode, M. J.
Bonell, B. T.
Creighton, L. H
Creswell, C. M.
Davin, C. C.
DeFazio, S. F.
Duncan, J. T., Jr.
Garren, J. T.
Goldstein, D. N.
Graves, J P.
Hill, B. Spaulding
Kappus, H. C.
Kent, L. T.
Kleinpell, W. C.
Kordecki, F. A.
Lipman, W. H.
Lokvam, L. H.
Lutz, J. J.
Mayfield, A. L.
Morrow, C. A.
Mudge, W. A., Jr.
Olsman, Louis
Pearson, J. B.
Pechous, C. E.
Pechous, Lillian
Pirsch, Margaret V.
Powell, R. A.
Randall, A. J.
Rattan, W. C.
Rauch, A. M.
Rauen, L. M.
Richards, C. G
Richards, J. N.
Rufflo, A. F.
Sattler, C. A.
Schlenker, L. T.
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.
Siegel, Morris
Stewart, W. C.
Swift, W. J.
Turner, Lewis III
Ulrich, C. F.
Weber, G. R.
Welsch, R. G.
Williams, F. C., Jr.

Kewaskum:
Edwards, R. G.

Kewaunee:
Nesemann, R. M.
Witcpalek, E. W.
Witcpalek, W. W.

Kiel:
Nauth, D. F
Theiler, A. C.
Twohig, G. J.

Kimberly:
Curtin, D. W.
Gage, Ralph S.

King:
Hathaway, G. J.
Montgomery, R. C.

Kohler:
Gascoigne, C. C.
Rowe, D. M.

La Crosse:
Anderson, P. D.
Bach, A. C.
Bruder, V. F. J.
Buchman, D. M.
Burich, H. F.
Carlsson, E. S.
Cook, A. A.
Daley, D. M.
Davies, May A.
Dietz, P. C.
Doyle, D. F.
Egan, G. J., Jr.
Egan, J. F.
Ernst, F. W.
Flynn, R. E.
Gallagher, E. E.
Gallagher, F. J.
Gatterdam, P. C
Gilbert, R. L.
Gray, R. H.
Gundersen, A. H.
Gundersen, Gunnar
Gundersen, S. B
Gundersen, T. E.
Gustafson, Everette
Harman, J. C.
Heraty, J. E.
Hickey, A. W.
Himmelsbach, W. A.
Hulick, P. V.
Jaeck, James L.
Jones, W. J.
Kelly, C. M., Jr.
Leiby, R. W., Jr.
Mansheim, B. J.
McCann, John P.
McGarty, M. A.
McMahon, R. E.
McNamara, T. B.
Midelfort, C. F.
O'Meara, M. T.
Pauly, James P.
Perry, E. L.
Phillips, P. W.
Ramlow, R. W.
Rasmus, R. B.
Reay, G. R.
Richter, J. R.
Ridout, G. B.
Rutter, Thomas
Satory, J. J.
Schmidt, L. R.
Schneeberger, E. J.
Sevenants, J. J.
Simones, J. J.
Sivertson, Martin
Skemp, G. E.
Smith, D. S.
Swarthout, Edyth C.
Uhrich, G. I.
Wolf, F. H.

Ladysmith:
Bauer, W. B. A. J.
Bennett, R. P.

Lundmark, L. M.
Murphy, J. E.
Pagel, H. F.

La Farge:
Gollin, F. F.

Lake Geneva:
Bischof, H. F.
Brady, C. J.
Hindall, B. C.
Hudson, E. D.
Jeffers, D. H.
Jeffers, D. H., Jr.

Lake Mills:
Eck, G. E.
Netzow, E. J.
Peterson, M. G.
Schoenecker, E. A.
Turcott, R. A.

Lancaster:
Bauman, K. L.
Becher, L. E.
Carey, H. W.
Houghton, E. M.
Jackson, R. D.

Land O'Lakes:
Eickhoff, E. C.

Laona:
Castaldo, E. F.
Ovitz, E. G.

Lena:
Rose. J. F.

Little Chute:
Verbrick, W. C.

Lodi:
Groves, R. J.
Irwin, W. G.

Loganville:
Jewell, E. L.

Lomira:
Fuller, J. D.

Loyal:
Hable, A. P.

Luxemburg:
Majeski, H. E.

Madison:
Aageson, C. W.
Albright, E. C.
Allen, J. R.
Allin, R. N.
Anderson, A. D.
Anderson, Evlyn M.
Anderson, R. B.
Angevine, D. M.
Ashman, H. C.
Atwood, D. C.
Bamforth, Betty J.
Becker, R. M.
Bell, P. P.
Benish, G. A.
Bennett, Maxine
Bentley, J. E.
Berger, J. V., Jr.
Berglund, George A.
Bernard, F. D.
Beyer, John A.
Bleckwenn, W. J.
Boner, A. J.
Brindley, B. I.
Britton, D. M.
Brown, F. A.
Bryan, A. W.
Buesseler, John A.
Burke, C. F.
Burke, Mead
Burke, Myra E.
Burns, E. M.
Burns, R. E.
Calvert, Charlotte
Campbell, R. E.
Canfield, Albert
Carter, H. M.
Chase, S. L.
Clatanoff, D. V.
Clausen, N. M.
Collins, R. F.
Cooksey, R. T.
Coon, H. M.
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Cowle, A. E.
Crepea, Seymour B.
Crosley, A. P., Jr.
Crumpton, C. W.
Cullen, R. E.
Curreri, A. R.
Curtis, J. K.
Davis, A. W.
Davis, F. A.
Davis, Milton, Jr.
Davis, V. T.
Dean, F. K.
Dean, J. C.
Dean, J. L.
Dean, J. P.
Derus, Gerald J.
Dickie, Helen A.
Dieter, D. G.
Dimond, W. B.
Dollard, J. E.
Domine, A. Z.
Doolittle, J. W.
Dornette, W. H.
Duehr, P. A.
Emanuel, D. A.
Erickson, T. C.
Ewell, G. H.
Farrell, R. X.
Fauerbach, Louis
Feig, Milton
Flinn, John H.
Foseid, Oscar F.
Fosmark, C. A.
Foster, M. A.
Foster, Ruth C.
Fromm, A. H.
Gale, J. W.
Ganser, L. J.
Ganser, W. J.
Garnett, G. M.
Gearhart, R. S.
Geppert, T. V.
Glover, B. H.
Golden, F. F.
Golden, P. B.
Gonce, J. E.
Gordon, E. S.
Greene, H. L.
Grumke, E. H.
Guilford, H. M.
Hamel, Merle O.
Hank, G. C.
Harmon, Doralea R.
Harper, C. S.
Harper, S. B.
Harris, J. W.
Hartmann, H. A.
Healy, W. G.
Hennen, R. J.
Hibma, O. V.
Hill, N. A.
Hoff, A. D.
Hogan, L. H.
Holmgren, L. E.
Hopkins, C. E.
Hummer, F. L.
Hunter, Amy Louise
Hurlbut, J. A.
Huston, E. S.
Huston, John H.
Huston, John, Jr.
Iams, A. M.
Jackson, A. S.
Jackson, R. H.
Jaeschke, W. H.
Joachim, F. G.
Johnson, F. C.
Johnson, S. A. M.
Jorris, E. H.
Juster, E. M.
Kabler, J. D.
Kant, Fritz
Kay, H. M.
Kemp, T. S.
Kilpatrick, Leslie G.
Kincaid, C. K.
Korst, D. R.
Krehl, W. H.
Kundert, P. R.
Kurtz, C. M.
Kurtz, Esther C.
Lacke, C. L.
Land, J. F.
Larkin, C. P.
Larson, F. C.
Lawrence, P. J.
Lee, James M.
Lemmer, K. E.
Leonard, T. A.
Lewis, W. C.
Lindsay, W. T.
Littig, L. V.
Lorenz, T. H.
Loveland, Pearl M.
Ludden, R. H.
Luetke, W. V.
Mahaffey, H. W.
Mailer, A. R.
Malec, J. P.
Maloney, F. G.
Maloof, G. J.
Marlow, Gordon V.
Marsden, W. H.
McClung, John L.
McCormick, S. A.
McDermott, John P.
McDonough, K. B.
McGary, Lester
McIllece, Patricia E.
McIntosh, R. L.
McMurray, Ora R.
Meisekothen, W. E.
Mendenhall, J. T.
Meyer, O. O.
Middleton, W. S.
Miller, J. E.
Mohs, F. E.
Mueller, John J.
Musser, M. J., Jr.
Nelson, O. O.
Nereim, T. J.
Nesbit, M. E.
Neupert, C. N.
Newman, J. R.
Noll, D. J.
Nordby, E. J.
Oakley, Dorothy W.
O'Connor, Robert E.
Okagaki, H. I.
Oosterhous, G. E.
Orth, O. S.
Osborn, L. A.
Parkin, R. C.
Parks, H. K.
Paul, L. W.
Peters, H. A.
Peterson, D. A.
Petsch, K. R.
Piper, P. G.
Pohle, E. A.
Prouty, L. R.
Prouty, Margaret
Puestow, K. L.
Quisling, A. A.
Quisling, R. A.
Quisling, Sverre
Reese, H. H.
Reznichek, C. G.
Richtsmeier, A. J.
Ris, Hania W.
Roberts, L. M.
Roemer, E. P.
Rogers, S. C.
Roisum, B. H.
Rounds, W. M.
Rowe, G. G.
Ryan, T. E.
Ryder, E. K., Jr.
Salick, J. A.
Schafer, Etheldred L.
Schmidt, E. R.
Schmitz, R. C.
Schneiders, E. F.
Schoenenberger, A. P.
Schroeder, C. F.
Schroeder, J. M.
Schubert, C. K.
Schuele, D. T.
Schwittay, Addie M.
Shapiro, H. H.
Sherman, C. F.
Shumate, J. K.
Siebecker, K. L.
Sims, J. L.
Sinaiko, R. P.
Sisk, I. R.
Smith, Max M.
Sonneland, A. M.
Soucek, Adolph
Sprague, J. T.
Sprague, L. V.
Stebbins, G. G.
Stebbins, W. W.
Steeper, J. R.
Stehr, A. C.
Steinhaus, J. E.
Stevenson, L. B.
Stiennon, O. A.
Stoerker, Ruth A.
Stone, Mildred M.
Stoops, C. W.
Stovall, W. D.
Straughn, R. A.
Suckle, H. M.
Supernaw, J. S.
Taborsky, C. R.
Talbot, J. R.
Tanner, W. A.
Tatum, A. L.
Taylor, F. B.
Tenney, H. Kent
Tenney, Horace K., III
Thornton, Madeline J.
Tormey, A. R.
Tormey, T. W.
Trautmann, Henry
Tweeten, J. K.
Urben, W. J.
Van Duser, A. L.
Van Gemert, J. G.
Vingom, C. O.
Vinograd, S. P.
Waddell, J. G.
Washburne, Annette C.
Waskow, W. L.
Wasserburger, R. H.
Waters, D. D.
Wear, J. B.
Weinstein, A. B.
Welke, E. G.
Werrell, W. A.
Weston, F. L.
Wheeler, R. M.
White, D. H., Jr.
Wilkie, J. M.
Williams, D. L.
Wirig, M. H.
Wirka, H. W.
Wixson, R. C.
Worley, Gordon
Wylde, R. M.
Young, W. P.

Manawa:
Irvine, R. K.

Manitowoc:
Banker, R. J.
Belson, H. J.
Bonner, N. A.
Davis, N. S., Jr.
Donohue, W. E.
Erdmann, N. C.
Gregory, L. W.
Hammond, F. W.
Hammond, R. W.
Hoffman, G. M.
Lynch, J. D.
Pick, D. M.
Puestow, R. C.
Radl, C. J.
Randolph, R. C.
Randolph, W. C.
Rau, G. A.
Rauch, W. A.
Rees, T. H.
Schaefer, H. E.
Scherping, W. H.
Shaw, Jesse W.
Simon, G. M.
Smejkal, W. F.
Sobush, L. D.
Steckbauer, J. W.
Strong, R. G.
Teitgen, Arthur
Teitgen, T. A.
Thorpe, R. F.
Wall, C. E.
Yost, P. G.
Zibel, Milton

Marathon:
Kampine, C. E.

Maribel:
May, J. H.

Marinette:
Bell, J. M.
Boren, C. H.
Boren, Clark H.
Boren, J. W., Jr.
Duer, G. R.
Koepp, C. E.
May, J. V.
McCanna, P. R.
Moss, K. J.
Nadeau, A. T.
Pinegar, K. G.
Schroeder, H. F.
Zeratsky, J. D.

Marion:
McInnis, W. R.

Markesan:
Cupery, D. P.
Pelton, R. S.

Marshfield:
Baldwin, Elizabeth
Baldwin, R. S.
Boeckman, F. A.
Burns, J. L., Jr.
Custer, G. S., Jr.
Dangle, Harland C.
Doege, K. H.
Doege, P. F.
Epstein, Stephan
Gouze, F. J.
Heersma, J. R.
Helland, N. J.
Lewis, R. F., Jr.
Macht, A. J.
Magnin, George E.
Mason, R. W.
McCormick, G. L.
McDonell, T. H.
Montz, C. R.
Potter, R. P.
Rice, T. J.
Rowe, R. J.
Suits, J. J.
Theisen, J. K.
Vedder, C. A.
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Wickham, J. M.
Wink, R. H.

Mauston:
Griffin, V. M.
Hess, J. S.
Thompson, J. E.
Tverberg, M. S.
Vedner, J. H.

Mayville:
Bachhuber, F. G.
Parish, G. A.
Royce, M. E.

Mazomanie:
Schultz, Isadore

McFarland:
McBride, Wm. P. L.

Medford:
Elvis, E. B.
Meyer, W. W.
Nystrum, L. E.
Nystrum, R. C.

Mellen:
Lockhart, C. W.

Melrose:
Lavine, I. H.

Menasha:
Conway, J. E.
Corry, L. F.
Forkin, G. E.
Hildebrand, G. B.
Hildebrand, W. B.
Horn, G. O.
Jensen, F. G.
Jensen, R. A.
Nebel, J. R.
O'Brien, P. T.
Pratt, G. N., Jr.
Schwei, G. P.

Menomonee Falls:
Burkhardt, E. W.
Domann, W. G.
Schloemer, H. F.

Menomonie:
Buckley, C. H.
Cook, F. D.
Drescher, A. A.
Gardner, Robert J.
Halgren, J. A.
Lee, S. R.
Lumsden, Wm.
McMahon, A. E.
O'Neill, J. W.
Quilling, P. A.
Steves, B. J.

Mercer:
Hiatt, W. R.
Kleinboehl, J. W.

Merrill:
Bayer, L. J.
Bayer, W. H.
Braun, W. E.
Kelley, F. H.
Lane, F. C.
Lewinnek, Walter
Millenbah, J. D.
Morris, K. A.
Ravn, Bjarne
Ravn, E. O.

Merrillan:
Schwarz, S. G.

Middleton:
Heighway, T. F.
Reis, L. N.
Stricker, M. F.

Milltown:
Hohf, A. H.

Milton:
Burdick, H. L.
Crosley, G. E.
Davis, M. D.

Milton Junction:
Holmes, J. F.
Vogel, T. L.

Milwaukee:
Abrams, J. E.
Ackerman, J. S.
Adamkiewicz, J. J.
Aguirre, M. R.
Allen, L. L.
Alston, J. W.
Altmeyer, J. R.
Altshuler, C. H.
Ansfield, D. J.
Antonmattei, J. C.
Apfelberg, H. J.
Appleby, K. B.
Arkins, J. A.
Armbruster, J. L.
Arnesen, P. M.
Atkinson, C. T.
Ausman, D. C.
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Avellone, B. M.
Axelrod, Sidney
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Babbitt, D. P.
Babbitz, A. L.
Babbitz, S. G.
Babby, Louis
Bach, E. C.
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Bachhuber, E. A.
Backus, E. A.
Baier, A. R.
Baker, V. L
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Baldi, J. B.
Baldigo, E. M.
Balistreri, Frank
Bardenwerper, H. E.
Barrock, J. J.
Barta, E. F.
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Bauer, C. A.
Bauman, R. O.
Baumann, A. J.
Baumgart, C. H.
Baumle, B. J.
Bechmann, Fred
Becker, Barney B.
Becker, I. M.
Beckman, Harry
Beezy, Reuben
Behnke, E. J.
Belfus, F. H.
Belknap, E. L.
Bellehumeur, C. E. P.
Bemis, E. L.
Bender, B. I.
Benjamin, H. B.
Bensman, L. L.
Benton, R. W.
Bercey, J. E.
Bergmann, G. J.
Berner, C. L.
Bernhard, L. A.
Bernhart, E. L.
Beutler, A. D.
Bickler, E. P.
Bielefeld, Mary E.
Biller, J. H.
Biller, S. E.
Birge, E. A.
Bittle, K. A.
Black, S. B.
Blanchard, H. H.
Blankstein, S. S.
Blount, W. P.
Blumenthal, R. W.
Bodden, A. M.
Bolger, J. V.
Bolger, J. V., Jr.
Bonan, J. D.
Bond, John M.
Bookhamer, J. W.
Borman, M. C.
Bornstein, Max
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Borowski, T. P.
Bortin, M. M.
Bourne, N. W.
Boxer, L. M.
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Brah, W. A.
Brandt, E. F.
Brazy, R. R.
Brennan, J. J.
Brewer, B. J.
Brey, P. F.
Briggs, M. C.
Brillman, C. R.
Broadbent, Mary
Brook, J. J.
Brunkhorst, R. O.
Brzezinski, E. A.
Budny, C. L.
Bunkfeldt, Frederick, Jr.
Burden, J. G.
Burgess, G. F., Jr.
Busby, W. W.
Buscaglia, A. T.
Buscaglia, C. J.
Bussey, A. D.
Buszkiewicz, T. S.
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Callahan, John W.
Callan, P. L.
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Calvy, D. W.
Calvy, T. L.
Cannon, H. J.
Carl, E. E.
Carl, E. F.
Carlson, D. J.
Carroll, P. E.
Carter, J. M.
Cary, J. F.
Cash, I. I.
Casper, W. T.
Cassidy, R. H.
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Cervenansky, A. A.
Chamberlain, J. O.
Chambers, R. K.
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Chapman, B. L.
Charles, J. D.
Chase, Jules
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Churchill, B. P.
Clarke, B. E.
Claudon, D. B.
Cleveland, David
Coffey, S. E.
Coffey, W. L., Jr.
Collentine, G. E.
Collentine, G. E., Jr.
Collopy, P. J.
Conen, W. J.
Conley, J. E.
Conroy, C. F.
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Cordes, V. J.
Coriell, H. L.
Cowan, I. I.
Cox, J. A.
Cralte, E. J
Cramer, R. P.
Cron, R. S.
Crottier, C. J.
Curry, J. C.
Dallwig, E. L.
Dallwig, H. C.
Daniels, E. R.
Dasler, T. W.
Darling, F. E., Sr.
Darling, F. E., Jr.
Darling, S. J.
Dasler, T. W.
Davidoff, I. Z.
Davies, J. A., Jr.
Davis, D. P.
Dawson, D. L.
Dean, G. W.
Decker, H. G.
Demeter, N. D.
Derse, F. R.
Devitt, J. S.
Diamond, C. O.
Dishmaker, M. C.
Dix, C. R.
Docktor, John P.
Dorn, A. S.
Downes, Virginia
Drew, F. E.
Dricken, H. N.
Drischler, W. H.
Drozewski, M. F.
Dudenhofer, P. A.
Dundon, J. R.
Dunker, G. O.
Dunst, C. G.
Dvorak, H. J.
Eberbach, C. W.
Eby, L. G.
Edelman, Elsa B.
Egan, W. J.
Eichenberger, C. R.
Eisenberg, E. E.
Eisenberg, L. A.
Eisenberg, P. J.
Elconin, D. V.
End, E. M.
End, J. A.
Enzer, Norbert
Epperson, K. D.
Epstein, Ely
Erbes, John
Esser, J. H.
Estrada, Isabel V.
Evans, S. M.
Evrard, J. R.
Faber, C. A.
Falecki, J. W.
Falsetti, F. P.
Fant, J. R.
Farrell, H. J.
Fechter, F. J.
Fechter, F. R.
Feierstein, W. E.
Feiman, L. H.
Feld, S. M.
Feldman, E. I.
Fellman, G. H.
Fetherston, J. P.
Fetherston, J. P., Jr.
Fetherston, W. C.
Fidler, Alan B.
Fidler, Charles
Finn, C. J.
Fisher, Laura M. D.
Fitzgerald, G. F.
Fitzgerald, R. E.
Fitzsimmons, Antoinette V.
Fleischmann, J. A.
Fletcher, H. A.
Flood, R. E.
Flynn, R. T.
Foerster, F. E.
Foerster, H. R.
Foerster, O. H.
Foley, L. J.
Fons, J. W.
Foregger, Richard
Fortier, C. A. H.
Fox, M. J.
Fox, Milton J.
Fox, M. S.
Frackelton, W. H.
Franklin, Emil
Franklin, Isadore
Franklin, S. N.
Frawley, D. D.
Freedman, M. S.
Frey, P. G.
Frisch, J. G.
Frisch, R. A.
Froede, H. E.
Froelich, J. A.
Fulton, James W.
Gabor, M. E.
Gaenslen, F. G.
Galasinski, R. E.
Gallimore, R. G.
Garens, R. W.
Garland, J. G.

Garland, T. H.
Garner, L. L.
Garvey, J. L.
Gatherum, D. H.
Gaunt, J. J.
Gaynon, I. E.
Gebert, W. H.
Gebhard, U. E.
Gecht, E. A.
Geiger, Sara G.
Gendlin, N. A.
Gertenbach, E. O.
Gilbert, Joseph
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Giller, Herbert
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Glassy, F. J.
Glisch, W. P.
Goldberg, Nat.
Goldberger, Esther W.
Goodman, J. A.
Goodman, J. S.
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Goodsitt, A. H.
Gorder, A. C.
Gordon, N. F.
Gorens, S. W.
Gorenstein, Leonard
Gramling, J. J.
Gramling, J. J., Jr.
Greenberg, A. I.
Greenberg, Maurice
Greenwalt, T. J.
Griffith, J C.
Groh, J. E.
Grossman, N. M.
Grossmann E E.
Gruender, J. E.
Gruhl, Helen V.
Guardalabene, Vito
Gudex, V. A.
Guerin, L. H.
Gumerman, G. J.
Gute, E. B.
Gutglass, M. F.
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Guzzetta, P. C., Jr.
Guzzetta, V. J.
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Hankwitz, A. W.
Hansen, A. C.
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Harris, Wm. C.
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Hertel, A. J.
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High, H. C., Jr.
Hilger, Wm. A.
Hiller, R. I.
Hiller, S. J.
Hilliard, G. W., Jr.
Hilrich, Nathan M.
Himes, Joseph
Hipke, L. W.
Hipke, M. M.
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Hofmeister, F. J.
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Holm, A. G.
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Houghton, W. J.
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Joseph, W. A.
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Kah, W. W.
Kalb, C. H.
Kane, A. M.
Kanin, H. J.
Karen, Robert
Karr, J. K.
Kassowitz, K. E.
Kaufman, Bernhard
Kaufman, K. K.
Kaufman, L. W.
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Kilkenny, G. S.
King, J. J.
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Koch, M. J.
Kocovsky, E. C.
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Kohn, A. M.
Kohn, S. E.
Kolman, Isadore I.
Koppa, J. F.
Korducki, Stanley A.
Kores, Vernon E.
Kovacs, Arthur
Kozina, F. J.
Kozina, V. J.
Kramoris, F. H.
Krembs, M. A.
Kretchmar, J. S.
Kretchmar, L. H.
Kretchmar, Morris
Kreuter, G. C.
Krill, Richard J.
Kritter, F. J.
Kriz-Hettwer, Rose
Krueger, F. J.
Krumblegel, E. R.
Krumenacher, F. P.
Kruszewski, J. L.
Krygier, A. J.
Krygler, W. L.
Kuehn, Eleanor V.
Kuhn, H. J.
Kuhn, M. J.
Kult, A. S.
Kurzon, Alvin M.
Kustermann, A. F.
Kuzdas, J. R.
Kuzma, J. F.
Kwapy, C. R.
La Bissoniere, P. G.
Ladewig, H. C.
Lang, V. F.
Langjahr, A. R.
Larkey, Jay A.
La Susa, T. J.
Leach, J. E.
Lee, H. J.
Lee, P. A.
Leitch, G. W.
Lepley, Derward, Jr.
Leslie, C. L.
Le Tellier, Robert P.
Lettenberger, Joseph
Levin, A. J.
Levin, J. D.
Levine, Abram
Levy, E. S.
Lewis, Marian
Liebl, E. R.
Liebman, Albert
Liefert, W. C.
Light, George
Lillie, R. H.
Lindert, M. C. F.
Lobedan, E. T
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Long, C. W.
Lungmus, B. A.
Lustok, M. J.
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Madison, J. D.
Majewski, J. T.
Malloy, T. G.
Malnekoff, B. J.
Mann, R. W.
Marck, Abraham
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Marquardt, C. R.
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Mason, E. W.
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Mayer, H. H.
McBeath, N. E.
McCabe, John
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McCann, Edith F.
McCarty, R. T.
McCormack, M. T.
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McCormick, T. F.
McDonald, C. F.
McDonald, R. E.
McElligott, J. A.
McKittrick, N. W.
McLaughlin, B. C.
McMahon, F. B.
McMahon, H. O.
McNamara, L. V.
McNary, J. F.
Melamed, Abraham
Mellencamp, F. J.
Meloy, G. E.
Mendeloff, Elton
Mendeloff, Hyman
Mendez, R. G.
Mensing, E. H.
Merten, A. N. E.
Messmer, Clemens
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Mikolajczak, N. A.
Millen, F. J.
Miller, E. W.
Miller, H. L.
Millington, P. E.
Miner, D. L.
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Mitz, Morris
Moel, Morris
Molsberry, J. M.
Monroe, M. W.
Montgomery, R. P.
Mookerjee, M. K.
Moore, G. E.
Morgan, J. E.
Morgan, S. F.
Morter, H. V.
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Mountain, D. C.
Muehlhaus, F. R.
Mueller, G. F.
Mueller, Nina T
Muenzner, R. J.
Mufson, J. A.
Murphy, F. D.
Murphy, J. A.
Murphy, T. R.
Murphy, W J
Muskat, Irving
Narodick, B. G.
Natenshon, A. L.
Nebel, Harold
Nelson, M. W.
Nichols, C. H.
Niland, P. J
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Nimz, F. N.
Nimz, R. A.
Northey, T. M.
Norton, R. C.
Oberbreckling, P. E.
O'Connor, R. D.
O'Hara, J. J.
Ohren, I. R.
O'Leary, E. B.
Olinger, J. K
Olsen, A. H.
Olsen, Maurice
Olson, C. R.
O'Malley, T. S.
O'Malley, W. P.
O'Neill, Philip B.
Orban, L. C
Osher, N. W.
Oswald, Frederick
Ottenstein, H. H.
Otto, Owen
Ovitt, D. W.
Owen, G. C.
Owen, J. D.
Owens, A. J.
Oxman, E. M.
Ozonoff, J. B.
Pallasch, F. J
Panetti, H E.
Paquette, L. J.
Paulbeck, T. M.
Pedersen, Elaine K.
Peelen, A. W.
Perlson, P. H.
Perssion, Leo B.
Pessin, S. B.
Peterman, M. G.
Peters, B. J.
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Peterson, E. F.
Peterson, J. C.
Pfeffer, E. N.
Pfeifer, W. M.
Phillips, W. S.
Pierson, P. S.
Pink, J. J.
Pinney, J. C.
Pisciotta, A. V.
Pleyte, A. A.
Pohle, H. W.
Polacheck, W. S.
Pollack, S. K
Popp, Albert
Powers, H. W.
Presti, A. A.
Price, D. J.
Prudowsky, H. H.
Pugh, G. J.
Pulito, F. J.
Purtell, P J
Purtell, R. F.
Quick, A. J.
Quick, E. W.
Rabin, Allen
Radai, J. L.
Raine, Forrester
Ramin, J. E.
Ramlow, L. W.
Rand, Harold
Rank, R. T
Rastetter, J. W.
Rath, E. K.
Ratke, Donald
Ravitz, L. A.
Raymond, A. J.
Regan, J. M.
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Reifenrath, I. B.
Reinke, C. C.

Rettig, E. H.
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Rice, E. L.
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Robbins, J. M.
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Roberts, D. W.
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Roethke, Anne E.
Rogers, E. H.
Rogers, M. F.
Rolfs, T. H.
Roncke, G. J.
Rose, Mona
Rose, W. R.
Rosenbaum, F. F.
Rosenbaum, M. K.
Rosenberg, S. W.
Rosenberger, A. I.
Rosenheimer, L. M.
Rosenthal, Samuel
Ross, F. A.
Rothman, L. E.
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Roubik, J. J.
Rowlands, O. B.
Royce, Owen, Jr.
Ruch, D. M.
Rueth, J. E.
Ruppa, Rex
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Ruskin, B. A.
Russell, R. J. M.
Ryan, P. W.
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Sabljak, E. J.
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Saketos, T. P.
Salinko, S. S.
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Sander, O. A.
Sanders, A. C., Jr.
Sanfelippo, A. J.
Santer, D. G.
Santilli, M. A.
Sarfatty, I. J.
Sargent, J. W.
Sass, L. C.
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Sauter, K. E.
Savage, G. W.
Schacht, W. J
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Schalmo, E. H., Jr.
Schelble, E. J.
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Schlaepfer, Karl
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Schnapp, A. C.
Schneeberger, L. J.
Schneider, C. C.
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Schoenkerman, B. B.
Scholter, E. A. W.
Schowalter, R. P.
Schroeder, C. M.
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Schubert, F. J.
Schuenzel, L. G. A.
Schuler, F. X.
Schulz, Irwin
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Schutte, A. G.
Schuyler, R. M.
Schwab, R. L.
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Seefeld, P. H.
Seegers, F. W.
Seelman, A. G.
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Selle, F. S.
Seng, W. L.
Sengpiel, G. W.
Senn, Ulrich
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Servis, L. T.
Shaiken, Joseph
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Shutkin, M. W.
Shutter, H. W.
Silbar, J. D.
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Slomovitz, Zachary
Slomowitz, Jonathan
Slotnik, I. L.
Slutzky, Nathan
Smigielski, K. M.
Smith, J. W.
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Spear, H. Gladys
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Squier, T. L.
Stamm, L. P.
Stark, R. M.
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Stefanez, J. S.
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Sulek, A. E.
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Swartz, L. W.
Sweet, S. J.
Sydow, Wm. O.
Szilagyi, M. J.
Szymarek, J. E.
Tabachnick, Harry
Tacke, A. W.
Tashkin, E. H.
Tax, A. H.
Taxman, J. E.
Taylor, J. Gurney
Tegtmeyer, G. F.
Teitgen, R. E.
Temple, J. W.
Teplin, Ervin
Terry, J. W.
Tessier, A. F.
Thatcher, D. S.
Thoma, J. W.
Thomas, C. O.
Thomas, Elaine M.
Thomas, W. D.
Thompson, R. D.
Thorstensen, A. H.
Thranow, J. A.
Thurwachter, L. F., Jr.
Tillson, E. M.
Toenhart, O. E.
Tolan, T. L.
Tolwinsky, Nathan
Torcivia, S. S.
Trangsrud, H. A.
Treskow, F. G.
Trimborn, B. A.
Tuft, W. R.
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Turney, C. F.
Twelmeyer, H. F.
Urdan, B. E.
Usow, E. J.
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Vaccaro, J. E.
Van Hecke, L. J.
Van Vleet, Mary
Veit, Henry
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Wade, Chester
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Waisman, R. C.
Waldeck, E. A.
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Warner, R. C.
Warschauer, Bruno
Warth, C. G.
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Weisel, Wilson
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Wendt, W. P.
Wepfer, J. F.
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Whalen, G. E.
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Wiener, Kurt
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Wild, J. P.
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Wisniewski, P. P.
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Wong, V. J.
Wright, H. H.
Wyland, J. S.
Wyman, J. F.
Wynn, S. K.
Yaffe, Aaron
Yunck, R. E.
Zahl, W. H.
Zaun, J. J., Jr.
Zawodny, S. E.
Ziegler, C. T.
Zillmer, Helen J.
Zmyslony, W. P.
Zubatsky, D. J.

Mineral Point:
Hamlin, W. D.
Hohler, E. J.
Ludden, H. D.
White, C. L.

Minocqua:
Huber, G. W.
Sprague, J. P.

Mishicot:
Skwor, C. J.

Mondovi:
Gillette, F. J.
Johnson, B. F.
Meyer, C. F.
Sharp, D. S.
Walker, J. P.

Monroe:
Barry, G. R.
Baumle, C. E.
Bear, N. E.
Bear, W. G.
Blum, O. S.
Brunkow, B. H.
Eckstam, E. E.
Fencil, W. J.
Gnagi, W. B., Jr.
Irvin, J. M.
Kindschi, L. G.
Kundert, F. W.
Mings, D. E
Moore, L. A.
Olson, M. J.
Ruehlman, D. D.
Schindler, J. A.
Snowden, P. W.
Springer, D. W.
Stiles, F. C.
Weir, J. R.
Witte, K. B.
Zach, R G.

Montello:
Federman, E. H.
Inman, R. F.

Montfort:
Rasmussen, N. G.

Monticello:
Lucas, P. M.
Miller, C. O.

Montreal:
Baird, H. D.
Pierpont, J. M.

Mosinee:
Knoedler, W. A., Jr.

Mount Calvary:
Habermann, J. H.
Miller, J. F.

Mount Horeb:
Buckner, H. M.
Morrison, M. T.

Mukwonago:
Kern, E. E.
Voellings, W. J.

Muscoda:
Ackerman, E. T.
Klockow, W. E.

Muskego:
Buhl, J. L.
Kelm, G. J.

Neenah:
Anderson, G. R.
Beatty, S. R.
Beglinger, H. F.
Bonfiglio, R. G.
Brown, R. C.
Brunckhorst, F. O.
Canavan, J. P.
Graham, A. P.
Henning, Laura E.
Henning, R. E.
Kiefer, E. J.
Kirchgeorg, Clemens
Pansch, F. N.
Petersen, G. W.
Pitz, M. N.
Quade, R. H.
Regan, D. M.
Ryan, D. J.
Smith, F. H.
Smith, T. D.
Springer, V. G.
Strauser, E. R.
Talbot, A. E.

Neillsville:
Manz, K. F.
Overman, M. V.
Rosekrans, M. C.
Rosekrans, Sarah D.

Nekoosa:
Jaffee, M. L.

Neopit:
Knauf, J. W.

New Auburn:
Stang, H. M.

New Franken:
Looze, J. A.

New Glarus:
Francois, S. J.
Hicks, E. V.
Marty, P. H.

New Holstein:
Engel, A. C.
Larme, F. P.

New Lisbon:
Weston, C. L.

New London:
Borchardt, M. A.
Dernbach, G. P.
Monsted, J. W.
Pfelfer, F. J.
Schmallenberg, H. C.

New Richmond:
Armstrong, J. H.
Davis, R. R.
Drury, E. M.
Epley, O. H.
Gordon, John J.
Healy, J. P.

Niagara:
Maginn, Richard J.
McCormack, E. A.

Norwalk:
Allen, J. S.

Oconomowoc:
Caffrey, James F.
Feasler, C. H.
Grindrod, John M.
James, W. D.
Loughnan, A. J.
Matt, J. R.
Nammacher, T. H.
Rogers, A. F.
Stemper, Irene T.
Theobald, P. B.
Wilkinson, D. C.
Wilkinson, J. D.
Wilkinson, J. F.
Wilkinson, P. M.

Oconto:
Aageson, H. A.
Mohler, G. T.
Rogers, R. J.
Slaney, A. F.
Zantow, F. E.

Oconto Falls:
Rauchschwalbe, L. E.

Ogema:
Rinehart, B. M.

Omro:
Peck, D. D.
Schoenbechler, L. J.

Onalaska:
Reay, G. D.

Oregon:
Dukerschein, F. N.
Johnson, E. S.
Kellogg, L. S.

Orfordville:
McNair, E. R.

Osceola:
Simenstad, L. O.
Weller, L. J.

Oshkosh:
Apell, M. G.
Becker, D. B., Jr.
Behnke, C. H.
Bitter, R. H.
Brei, F. A.
Clark, W. E.
Connell, F. G.
Cummings, E. F.
Danforth, H. J.
Danforth, Q. H.
Emrich, P. S.
Gerth, R. E.
Graber, L. D.
Graiewski, S. J.
Greenwood, Ben. S.
Guenther, V. G.
Hahn, W. V.
Haines, M. C.
Haubrick, H. J.
Koehler, A. G.
Kronzer, J. J.
Kuhn, R. V.
Leibenson, S. J.
Linn, W. N.
Lockhart, J. W.
Lynch, G. V.
Lynch, T. S.
Meilicke, C. A.
Meli, J. V.
Meusel, H. H.
Monday, Harvey
Pfefferkorn, E. B.
Romberg, H. A.
Schein, J. E.
Steele, G. A.
Steen, M. H.
Wagner, R. F.
Wagner, W. A.
Wheeler, W. P.
Williams, E. B.
Winter, E. F.

Osseo:
Knutson, Oscar
Leasum, R. N.

Oxford:
Nafziger, E. G.

Palmyra:
Handeyside, R. G.

Pardeeville:
Winkler, H. A.

Park Falls:
Leahy, J. D.
Leahy, J. J.
Murphy, J. L.

Peshtigo:
Haasl, H. W.

Pewaukee:
Egloff, L. W.
Kelly, J. P.

Phelps:
Schmitt, R. W.

Phillips:
Niebauer, W. E.
Norviel, H. B.
Rens, J. L.
Van Hecke, D. S.

Plain:
Fowler, Paul H.

Platteville:
Andrew, C. H.
Bair, G. W.
Conklin, J. W.
Cunningham, Wilson
Doeringsfeld, H. L.
Moffett, J. L.
Soles, F. A.

Plum City:
Steiger, E. E.

Plymouth:
Brickbauer, A. J.
Dietsch, L. C.
Evers, R. H.
Mueller, J. F.
Radloff, A. C.
Steffan, L. J.
Weisse, H. A.

Portage:
Harkins, J. P.
Henney, C. W.
Henney, T. E.
Jones, W. W.
MacGregor, J. W.
Pavelsek, J. W.
Rueckert, R. R.
Saxe, J. J.
Taylor, S. F.
Taylor, W. A.
Tierney, E. F.

Port Edwards:
Backus, O. A.

Port Washington:
Barr, A. H.
Kauth, C. P.
Savage, G. F.
Stein, C. C.
Walsh, John F.

Pound:
Pelkey, R. B.

Poynette:
Dryer, R. B.
Focke, W. J.
Stevenson, D. J.

Prairie du Chien:
Dessloch, E. M.
Epley, V. C.
Farrell, T. F.
Satter, O. E.
Shapiro, H. L.

Prairie du Sac:
Trautmann, Milton
Zauft, G. F.

Prescott:
Laney, H. J.

Princeton:
Mueller, G. G.

Pulaski:
Brusky, S. F.
Shippy, V. J.

Racine:
Ageloff, Harry
Albino, J. M.
Bacon, G. A.
Barina, H. J.
Bennett, W. H.
Bliwas, Arnold
Brehm, H. G.
Brehm, H. J.
Buckley, W. E.
Burch, V. J.
Caton, J. R.
Christensen, F. C.
Christenson, C. W.
Constantine, C. E.
Cook, J. C.
Covell, K. W.
Dockery, J. N.
Docter, J. C.
Dunham, C. T.
Edwards, A. C.
Faber, S. J.
Fazen, L. E.
Fazen, L. E., Jr.
Gettelman, Sydney T.
Gillett, G. N.
Graf, A. E.
Grant, A. B.
Grinney, June L.
Grinney, L. R.
Hanson, W. C.
Hemmingsen, T. C.
Henken, J. F.
Henken, W. F.
Hilker, H. C.
Hilpert, F. M.
Hogan, J. H.
Jacobsen, A. J.
Jamieson, J. G.
Jones, Beatrice O.
Jones, L. E.
Kadin, Maurice
Kehl, K. C.
Keland, H. B.
Konnak, Wm. F.
Kreul, R. W.
Kreul, W. R.
Kurten, L. J.
Kurten, R. M.
Lehner, R. H.
Leitschuh, R. B.
Lifschutz, L. M.
Lindner, A. M.
MacVicar, E. L., Jr.
Madden, W. J.
Marek, F. B.
Mayer, R. J.
Miller, H. C.
Miller, W. C.
Newman, C. R.
Nickelsen, J. R.
Olson, E. S.
Petersen, J. J. G.
Peterson, R. O.
Pfeifer, E. C.
Pitts, Eugene H
Pope, F. W.
Postorino, J. D.
Rodick, J. C.
Roth, W. C.
Rothenmaier, G. L.
Schacht, E. W.
Schacht, R. J.
Schatz, W. R.
Scheible, F. J.
Scheller, R. F.
Schenkenberg, Grace E.
Schleper, A. J.
Schneller, E. J.
Schroeder, H. T.
Schuster, Myron
Skow, G. D.
Smith, L. W.
Smullen, G. H.
Steffen, Elizabeth A.
Thackeray, R. C.
von Jarchow, B. L.
Walters, H. G.
Williamson, W. H.
Woods, E. W.
Wright, R. S.

Randolph:
Horvath, D. C.

Random Lake:
Russell, J. A.

Reedsburg:
Booher, J. A.
Hanko, J. E.
Knight, Robert G.
Pawlisch, O. V.
Rouse, J. J.
Stadel, E. V.
Tibbits, J. A.

Reedsville:
Cary, E. C.

Rhinelander:
Bump, W. S.
Cline, Frances A.
Harter, A. F.
Haug, Thomas M.
Osborne, R. R.
Richards, C. A.
Schiek, I. E.
Schiek, I. E., Jr.
Simmons, W. K.
Thuerer, G. R.
Wright, Marvin

Rice Lake:
Eidsmoe, N. A.
Johnson, A. G.
MacMillan, D. G.
Maser, J. F.
Rydell, O. E.
Rydell, W. B.
Vaudreuil, W. F.

Richfield:
Kern, T. J.

Richland Center:
Edwards, W. C.
Glise, Roy C.
Hinke, D. H.
Housner, R. E.
Meyer, K. H.
Parke, George, Jr.
Pippin, B. I.
Pippin, L. M.
Seidl, J. A.
Sholtes, C. A.
Spear, Jack
Taft, D. J.

Rio:
Maas, W. C.

Ripon:
Bachus, A. C.
Cole, D. F.
Dittmer, O. A.
Johnson, J. M.
La Ham, J. T.
Schuler, W. H.
Watson, E. L.

River Falls:
Cairns, R. U.
Gutzler, P. H.
Haskins, P. S.
Horswill, C. W.

Roberts:
Ford, A. M.

Rosholt:
Benn, V. A.

St. Croix Falls:
Belshe, J. C.
Riegel, F. B.
Riegel, J. A.

St. Nazianz:
Foley, M. E.

Sauk City:
Bachhuber, H. A.
Kraus, B. F.
Walsh, T. W.

Seymour:
Groendahl, R. C.
Hittner, V. J.
Sleb, L. H.

Sharon:
Schrock, J. B.

Shawano:
Arvold, D. S.
Bauer, Frederick
Cantwell, A. A.
Cantwell, R. C.
Henke, F. W.
Jeffries, Donald A.
Marsh, H. C.
Peterson, L. W.
Rivard, R. R.
Schutz, W. J.
Sebesta, A. J
Von Ruden, W. J.

Sheboygan:
Bassewitz, P. P.
Bock, A. B. C.
Bringe, J. W.
Cinelis, Ann A.
Differt, C. C.
Duckering, Florence A.
Eckardt, B. F.
Eigenberger, Friedrich
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Hidde, F. G.
Hildebrand, J. F.
Hoon, J. R.
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Huibregtse, W. G.
Juckem, G. J.
Keane, K. M.
Knauf, A. J.
Kolb, F. K.
Kovacic, J. F.
Marsho, B. S.
Mason, P. B.
McRoberts, J. W.
Meier, Wm. G.
Moir, Jane M.
Moir, W. W.
Nause, F. A.
Nause, F. P.
O'Donnell, S. P.
Pauly, L. F.
Pauly, R. C.
Schmitt, A. J.
Schott, E. G.
Schroeder, I. L.
Senty, R. M.
Simonson, L. M.
Simpson, R. M.
Squire, C. A.
Tasche, C. T.
Tasche, L. W.
Tompsett, A. C.
Van Driest, J. J.
Weber, C. J.
Weissler, J. B.
Winsauer, H. J.
Wood, H. R.
Wood, R. A.
Zaegel, R. L.
Ziel, H. A., Jr.

Sheboygan Falls:
Hansen, H. J.
Leighton, F. A.
Pfeiler, A. G.

Shell Lake:
Moen, D. V.
Welter, D. J.

Shiocton:
LaCroix, G. M.

Shullsburg:
Garland, D. J.
Gratiot, Mary P.
Hoesley, H. F.

Silver Lake:
De Witt, C. A.

Siren:
Grindell, G. A.

Slinger:
Prefontaine, K. F.

Soldiers Grove:
Sannes, W. A.

Solon Springs:
Wilcox, A. G.

South Milwaukee:
Crigler, R. R.
Dempsey, G. P.
Flaherty, G. S.
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Murphy, G. V.
Oberfeld, H. H.
O'Leary, W. J.
Palese, J. A.
Rumph, C. L.

Sparta:
Beebe, D. C.
Beebe, S. D.
Brown, J. D.
Flynn, R. A.
Harris, A. J.
Lukasek, E. O.
Mannis, Harry
Van Susteren, J. A.
Williams, H. H., Jr.

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Callahan, H. T.

Spooner:
Goetsch, F. H.
Olson, L. J.
Sahs, M. H.

Spring Valley:
Hill, E. F.

Stanley:
La Breche, J. J.
Mathwig, R. J.
Overgard, A. W.

Statesan:
Pummer, L. R.
White, E. F.

Stevens Point:
Anderson, G. H.
Anderson, H. A.
Benn, H. P.
Crosby, E. P.
Dunn, A. G.
Erickson, J. R.
Fox, G. E.
Gehin, F. E.
Gramowski, W. A.
Iber, F. C.
Litzow, J. A.
Miller, S. R.
Reichardt, F. W.
Rice, M. G.
Sanders, R. H.
Sheehan, W. C.
Slater, R. H.
Sowka, A. J.
Sowka, P. N.
Wisiol, Erich

Stockbridge:
Knauf, J. A.

Stoughton:
Nordholm, V. W.
Peterson, R. K.
Schoenbeck, R. F.
Smedal, A. T.

Stratford:
Kroeplin, F. C.

Strum:
Pfeiffer, L. R.

Sturgeon Bay:
Beck, J. G.
Dorchester, D. E.
Grota, H. D.
Huff, F. C.
Muehlhauser, J. O.
Murphy, J. T.
Peters, H. R.
Sheets, W. G.

Sturtevant:
Peehn, F. G.

Sun Prairie:
Behrend, J. F.
Grab, J. A.
Nelson, E. J.
Peterson, Leo W.
Russell, W. T.

Superior:
Anderson, R. T.
Carpenter, E. E.
Doyle, T. J.
Droege, C. T.
Easton, J. W.
Ekblad, V. E.
Finn, Milton
Fruehauf, R. P.
Giesen, Charles W.
Giesen, Conrad W.
Heisel, J. G.
Johnson, F. G., Jr.
Kyllo, J. C.
Lavine, M. M.
McGill, J. W.
McGinnis, J. P.
Picard, C. J.
Reibold, F. W.
Rosin, L. R.
Sincock, H. A.
Stack, E. G., Jr.
Thompson, R. T.
Weisberg, J. H.

Suring:
Dougherty, J. S.
Sandgren, G. R.

Sussex:
Van Valin, E. C.

Theresa:
Langenfeld, G. P.
Langenfeld, P. F.

Thiensville:
Elbe, T. D.
Scholz, H. F.

Thorp:
Jorgensen, Eleanora F.
Jorgensen, P. B.
Neis, F. P.

Tigerton:
Heise, L. F.
Maurer, Siegfried
Rogers, R. M.

Tomah:
Konicek, R. G.
Kozarek, C. E.
Landmann, G. A.
Mubarak, J. S.

Tomahawk:
Adams, H. G.
Baker, G. R.
Baker, R. G.
Jarvis, D. F.
Jarvis, E. C.
McCormick, W. C.

Turtle Lake:
Halberg, A. C.

Twin Lakes:
Hogan, John

Two Rivers:
Kozelka, A. W.
Kuljis, D. A.
Marshall, W. S.
Martin, R. E.
Weld, S. L.
Zlatnik, A. P.

Union Grove:
Haedike, W. D.
McCracken, R. W.
Schulz, G. J.

Verona:
Weiland, H. P.

Viola:
Meboe, Joseph

Viroqua:
Ender, C. A.
Gulbrandsen, L. F.
Hirsch, R. S.
Oppert, H. E.
Starr, R. A.
Vig, De Verne W.
Vig, E. N.

Wabeno:
Reddick, G. H.
Tenley, O. S.

Walworth:
Coon, W. W.
Kroyer, T. J.

Washburn:
Guzzo, Harold

Waterford:
Bardenwerper, H. W.
Budnick, T. J.
Dietz, R. J.

Waterloo:
Allen, S. C.
Kennedy, F. H
Schmidt, Carl W.

Watertown:
Brazos, J. C.
Burzynski, E. E.
Dierker, O F
Epperson, D. P.
Hadley, John O.
Hahn, A. C.
Haney, F. C.
Miller, E. A.
Nowack, L. W.
Schmidt, Claude W.
Welbourne, R. P.
Zimmerman, F. H.

Waukesha:
Bartos, J. A.
Bolger, James V.
Bolger, James V., Jr.
Brown, W. E.
Campbell, P. E.
Campbell, W. B.
Clark, O. C.
Clothier, W. J. K.
Davies, E. B.
Davies, Gwilym
Edmondson, C. C.
Eisele, Paul L.
Frick, J. C.
Gantz, H. A.
Grosskopf, E. C.
Houston, H. S.
Merkow, William
Promer, J. E.
Scheele, F. M.
Schoene, F. C.
Seno, Elvira C.
Settlage, H. A.
Smirl, W. G.
Sweed, Aaron
Sydow, H. F.

Thompson, F. A.
Werra, B. J.
Werra, M. J.
Williams, A. J.
Wood, C. A.
Zietlow, F. G.

Waunakee:
Jackson, J. A.
Marquis, W. R.

Waupaca:
Boudry, M. O.
Haman, K. L.
Patterson, L. G.
Salan, Sam
Steiner, J. H.

Waupun:
Hebenstreit, A. J.
Hull, H. H.
Peterson, J. A.
Petters, W. J.
Reslock, C. P.
Schrank, L. W.
Schrank, R. E.
Wagner, W. A.

Wausau:
Balliet, C. M.
Becker, W. T.
Brick, E. B.
Brodhead, R. H.
Burek, A. W.
Burr, Thurl C., Jr.
Christensen, H. W.
Davis, Helen Crawford
Fechtner, H. H.
Fehland, H. R.
Flannery, J. V.
Flemming, E. E.
Foerster, J. M.
Freeman, D. J.
Freeman, J. M.
Green, D. M.
Hammes, G. R.
Hendrickson, A. O.
Hendrickson, W. O.
Hoessel, A. W.
Jones, M. L.
Kelley, O. R.
Kordiyak, George
Larsen, R. B.
Ludwig, E. P.
McCandless, E. E.
Miller, W. C.
Norton, W. I.
Prehn, F. C.
Schroth, G. J.
Shannon, R. C.
Smith, B. K.
Smith, S. M. B.
Stahmer, A. H.
Stahmer, K. H.
Stevens, G. H.
Trumbo, J. K.
Wilson, O. M.
Yoran, C. M.

Wautoma:
Beck, A. A.
Darby, R. C.
Shemanski, L. S.
Slattery, F. G.

Wauwatosa:
Banyai, A. L.
Beck, K. H.
Beffel, J. M.
Brand, W. D.
Brussock, W. A.
Burgardt, G. F.
Cadden, A. V.
Curtis, William C.
Danziger, Lewis
Dettmann, N. F.
Deysach, L. J.
Donath, L. H.
Engstrom, W. W.
Fifrick, L. L.
Glienke, C. F.
Harkness, John W.
Kasak, Michael
Kehlnhofer, F. H.
Kindwall, J. A.
Klopfer, W. P.
Kocovsky, C. J.
Kradwell, W. T.
Liefert, K. A.
Lunseth, J. H.
McCormick, G. E.
Morrison, R. C.
Mueller, Joseph J.
Nordin, P. F.
O'Connell, James R.
Osgood, C. W
Pendergast, T. J.
Puchner, T. C.
Rettig, F. E.
Sargeant, H. W.
Seifert, K. A.
Seymer, L. A.
Stokdyk, G. A.
Tharinger, E. L.
Truitt, J. W.
Winters, K. J.
Worm, G. J.

Webster:
Maas, D. A.

West Allis:
Brumbaugh, E. V.
Collins, E. G.
Couch, J. R.
Couch, T. T.
Dohearty, W. H.
Everts, E. L.
Frederick, R. H.
Heinan, F. C.
Hermann, W. C.
Hotter, J. T.
Malensek, M. C.
Miller, L. E.
Nefches, M. S.
Ohlsen, M. P.
Olmstead, E. G.
Smits, R. H.
Stamm, M. P.
Stern, C. S.
Stern, L. S.
Thompson, L. L.
Toepfer, R. A.
Wilkinson, E. D.
Wilkinson, J. J.

West Bend:
Bauer, K. T.
Baumgartner, J. F.
Bernhardt, E. L.
Bush, F. I.
Driessel, R. H.
Driessel, S. J.
Frankow, R. O.
Grundahl, A. T.
Heidner, A. H.
Kauth, P. M.
Koehler, J. P.
Nielsen, W. A.
Pick, J. W.
Scheunemann, W. E.

Westby:
Bland, P. T.

West DePere:
Lenz, R. B.

Westfield:
Fredrick, H. Y.

West Salem:
Goedecke, R. H.
Wakefield, G. F.

Weyauwega:
Weller, E. A.

Whitehall:
MacCornack, R. L., Sr.
Simons, N. S.
Simonson, S. W.

Whitelaw:
Gutheil, D. A.

Whitewater:
Ambrose, S. H.
Meighan, P. P.
Miller, R. H.

Wild Rose:
Hadden, Shirley L.
Hong, Roy
Kjentvet, R. J.
Wichmann, R. D.

Williams Bay:
Wiswell, C. Y.

Winnebago:
Heywood, W. H.
Petersik, J. T.

Winneconne:
McDonald, D. H.

Wisconsin Dells:
Broderick, C. F.
Gissal, F. W.
Houghton, J. H.

Wisconsin Rapids:
Debus, E. E.
Garrison, R. E.
Glenn, E. C.
Handy, G. H.
Hulme, A. W.
Nelson, W. L.
Pomainville, F. X.
Pomainville, H. G.
Pomainville, L. C.
Schaller, J. W.
Shields, G. G.

Withee:
Johnson, J. W.

Wittenberg:
Olson, M. H.

Wonewoc:
Baker, H. P.

Wood:
Ciccantelli, Mark J.
Dessel, B. H.
Grueninger, A. J.
Harkavy, Leo
Kuhl, Howard L.
Lehman, R. H.
Levin, J. J.
Lubitz, J. M.
Maas, D. W.
Miller, P. L.
Myers, S. C.
Pfeffer, T. J.
Piaskoski, R. G.
Shanberge, J. N.
Sosman, Abe
Spencer, G. N.
Trachtenberg, L. H.
Webb, Wm. C.

Woodruff:
Newcomb, Kate P.
Pfeiffer, O. W.

Woodville:
Heiser, P. Arthur

Wrightstown:
Vande Loo, F. B

Wyocena:
de Neveu, A. V.

Members Serving in the Armed Forces

Albrecht, Donald J. --------Edwards AFB, California
Arneth, John J. ----------Milwaukee, Wisconsin
Ashe, H. S. ----------Cherry Point, North Carolina

Bachhuber, Hugo M. ----------Neosho, Missouri
Becker, R. J. ----------Columbus, Georgia
Benkendorf, Charles ----------Miami, Florida
Bordenave, G. J. ----P. M., San Francisco, California
Brook, J. J., Jr. ----------Albuquerque, New Mexico
Brown, R. C. ----------Alexandria, Virginia
Brown, W. F. ----------Washington, Pennsylvania
Buhl, Thomas L ----Travis Air Force Base, California
Bultema, James H. ----------Muskegon, Michigan

Caskey, H. S. ----------New York, New York
Cofrin, David A. ----------Enid, Oklahoma
Coheen, Jack J. ----------Fort Lewis, Washington
Cooney, Robert T. ----------San Francisco, California
Cornwall, Milton A. ----% P. M., New York, New York

Dall, Glenn Alfred --------Fort Sam Houston, Texas
Davis, F. J. ----------Oceanside, California
Dorman, T. W. ----------Oscoda, Michigan
Duffy, Haydon R. ----------El Toro, California

Ferguson, Samuel H. ----------El Paso, Texas
Foerster, H. R., Jr. ----------Milwaukee, Wisconsin
Foley, Thomas J. ----------Milwaukee, Wisconsin
Foster, Thomas D. --F.P.O., San Francisco, California
Frederick, John J. ----------Waco, Texas
Froehlke, Theodore P. ------Atterbury AFB, Indiana

Grubb, Kenneth P., Jr. ----------Evanston, Illinois

Hara, Kinge ----------P. M., Seattle, Washington
Harris, Henry W. ----------Aurora, Colorado
Heinz, Harold N. ----------Sheboygan, Wisconsin
Hering, G. V. ----------F.P.O., New York, New York
Hobbins, William B. ------Colorado Springs, Colorado
Holmes, Chester L. ----% P.M., New York, New York

Kagen, Louis ----------Milwaukee, Wisconsin
Kinsey, Jack La Vergne ----New London, Connecticut
Klobucar, J. J. ----------Fort Riley, Kansas
Kreissl, L. J., Jr. ----------Oakland, California
Kuehn, Alvin E. ----------Fort Sam Houston, Texas

Lamb, R. F. ----------Fort Sam Houston, Texas
Le Tellier, Mason S.----------No known address

Liebenow, R R.-----% P.M., San Francisco, California
Lipscomb, Thomas C.
----------Aberdeen Proving Ground, Maryland
Little, William J. --------Phoenixville, Pennsylvania
Longley, Bruce J. ----------Fort Knox, Kentucky
Lubing, H. N. ----------Great Lakes, Illinois

Matthiesen, Don E. ----------Corpus Christi, Texas
McCreary, William K. -------Temple City, California
Means, James A.---% P.M., San Francisco, California
Mehnert, J. H. ------F.P.O., San Francisco, California
Miller, John P.--Wright-Paterson AFB, Dayton, Ohio
Moore, James N. ----------Youngstown, Ohio

Nelson, Pierce D. ----------Quantico, Virginia
Nichols, George P. ----------Denver, Colorado
Nilles, J. E. --------% P.M., San Francisco, California

Ogilvie, O. Edward ----------Salt Lake City, Utah
Olson, Donald E. ----------Denver, Colorado
O'Malley, Richard J. ----------Milwaukee, Wisconsin

Podruch, Philip E.--% P.M., San Francisco, California

Quetsch, R. M. ----------San Francisco, California

Reik, R. P. ----------P. M., New York, New York
Rotter, Royal ----------Seattle, Washington

Sakaguchi, Shimpei ----------Oceanside, California
Salter, Robert K. ----------El Paso, Texas
Samuelson, Clarence----Scott Air Force Base, Illinois
Savino, Pasquale R. ----------Denver, Colorado
Schelbe, James A. ----------New York, New York
Schmidt, C. H. -----Castle Air Force Base, California
Schoen, Roland F. ----------New York, New York
Semmens, James P. ---------Port Chicago, California
Skroch, E. E. ------F.P.O., San Francisco, California
Stehlin, J. S., Jr. ----------Houston, Texas
Stollenwerk, Kenneth J. ----------Hood, Texas
Sweeney, Thomas C. ----------No known address

Taniguchi, Tukuso --P. M., San Francisco, California
Teresi, J. L. ----------Fort Bragg, North Carolina
Thiede, Walter H. ----------No known address

Watzke, Donald F. ------% P.M., Seattle, Washington
Worobec, R. N. ----------Fort Belvoir, Virginia

Zimmermann, B. M. ----------Warrington, Florida

Out-of-State Members

Allin, T. G. ----------Cincinnati, Ohio
Anderson, N. P. ----------No known address
Anderson, W. A. D. ----------Coral Gables, Florida
Aszman, P. E. ----------Miami, Florida

Baum, E. L. ----------Naples, Florida
Becker, J. F. ----------Chicago, Illinois
Bennett, J. C. ----------San Francisco, California
Beno, T. J. ----------Muncie, Indiana
Bleyer, L. F. ----------Providence, Rhode Island
Boren, James A. ----------Rochester, Minnesota
Brown, J. W. ----------Oakland, California
Bruns, D. H. ----------Phoenix, Arizona
Bryant, G. E. ----------Long Beach, California
Burns, T. A. ----------Portland, Oregon

Cahana, Stephen ----------Los Angeles, California
Christianson, H. B. ----------Rochester, Minnesota
Christofferson, J. W. --------Durham, North Carolina
Clasen, W. E. ----------Dallas, Texas
Coffin, L. E. ----------Tucson, Arizona
Creasy, Leurner E. ----------St. Petersburg, Florida
Crowley, W. P., Jr. ----------Rochester, Minnesota

Dedinsky, G. A. ----------Smock, Pennsylvania
Deiss, W. P., Jr. ----------Durham, North Carolina

Eisen, H. L. ----------Ontario, California
Ellenz, G B. ----------St. Paul, Minnesota

Fabric, Ben Lue ----------Miami Beach, Florida
Fitch, Edna ----------Pittsburgh, Pennsylvania
Fce, R. B. ----------Greeley, Colorado
Fox, J. C. ----------Hingham, Massachusetts
Freed, D. A. ----------West Union, Iowa
Frye, J. W. ----------Fresno, California

Ghormley, K. O. ----------Redlands, California
Gloss, A. J. ----------No known address
Gorenstein, L. M. ----------Speedway, Indiana
Grant, L. C., Jr. ----------Columbia, South Carolina
Gulbrandsen, Halbert ----------Denver, Colorado

Haley, H. B. ----------Boston, Massachusetts
Handa, Yoshio ----------Hines, Illinois
Hamnmond, D. F. ----------Stromsburg, Nebraska
Hayes, D. M. ----------Detroit, Michigan
Henschel, Ann Bardeen ------Saskatchewan, Canada
Hildebrand, J. F. ----------Detroit, Michigan
Hodgson, E. R. ----------Walla Walla, Washington
Horwich, Harry ----------No known address
Hugo, George J. ----------Campbell, California

Ives, Donald G. ----------No known address

Jacks, R. R. ----------Menard, Illinois
Jackson, R. C. ----------Rochester, Minnesota
Johnson, E. H. ----------Turlock, California
Johnson, H. C. ----------Eugene, Oregon

Kaye, Van Walter ----------Riverside, California
Keating, Joseph L. ----------Temple, Texas
Keller, L. W. ----------Webster, South Dakota
Keppler, L. L., Jr. ----------Parma, Ohio
Kersting, David W. ----------Chicago, Illinois
Kilkenny, T. E. --------Elizabethtown, Pennsylvania
Kozokoff, N. J. ----------Shaker Heights, Ohio

Lohrman, G. H. ----------Columbus, Ohio
Low, N. L. ----------Chicago, Illinois

Malloy, David J. ----------Maywood, Illinois
Mann, George A. ----------St. Paul, Minnesota
Masten, Mabel ----------Miami, Florida
McLeod, John J., Jr. ----------Rochester, Minnesota
McMahon, A. E., Jr. ----------Mason City, Iowa
McNichols, E. R. ----------Memphis, Tennessee
Megna, Salvatore ----------Tucson, Arizona
Merdinger, Walter F., Jr. --------Buffalo, New York
Miale, John B. ----------Miami, Florida
Morrison, Thomas ----------Joliet, Illinois

Nelson, F. F. ----------New York, New York
Nicolai, Charles H. ----------St. Louis, Missouri

O'Donnell, Mae J. ----------Wadsworth, Kansas
O'Neill, E. J. ----------No known address

Parkin, E. M.----------River Forest, Illinois
Peterson, Freddie N. ------Kingston, Jamaica, B.W.I.
Pfeifer, R. H ----------Birmingham, Alabama

Rhoades, A. L. ----------Danville, Pennsylvania
Ruchie, W. H. ----------Wilmer, Minnesota

Sage, J. H. ----------Palm Springs, California
Sanders, Donald D. ----------Salem, Oregon
Schaefer, Margaret A. ----------Aurora, Colorado
Sinnett, J. M. ----------Jacksonville, Florida
Sivertson, Sigurd E. ----------Rochester, Minnesota
Smith, Robin ----------Northridge, California
Smith, Woodruff ----------Aliquippa, Pennsylvania
Strand, Clarence M. ----------Chicago, Illinois
Sweeney, James D. ----------Spokane, Washington

Taschc, J. A. ----------Sarasota, Florida
Thimke, H. E. ----------Iowa City, Iowa
Thomas, W. C. ----------Brunswick, Georgia

Usow, John M. ----------Beverly Hills, California

van Baaren, H. J. ----------Toledo, Ohio
Van Kirk, F. W. ----------Beverly Hills, California
Van Riper, H. E. ----------New York, New York

Waters, R. M. ----------Orlando, Florida
Wells, May R. ----------Belleville, Illinois

Honorary Members of County and State Societies

Bradley, H. C. ----------Madison
Clark, P. F. ----------Madison
McCracken, R. W. ----------Union Grove
Meek, W. J. ----------Madison

Pusey, W. A. ----------Chicago, Illinois
Sisk, I. R. ----------Madison
Sullivan, W. E. ----------Madison
Taylor, J. Gurney ----------Miami, Fla.

Life Members of State Medical Society

Allen, W. J. ---------- Beloit

Baker, G. R. ---------- Tomahawk
Bayer, W. H. ---------- Merrill
Bear, W. G. ---------- Monroe
Beebe, S. D. ---------- Sparta
Bolton, E. L. ---------- Appleton
Boyce, S. R. ---------- Gays Mills
Brehm, H. J. ---------- Racine
Brooks, E. H. ---------- Bloomington
Brunckhorst, F. O. ---------- Neenah

Cairns, R. U. ---------- River Falls
Campbell, W. B. ---------- Waukesha
Caswell, H. O. ---------- Jefferson
Connell, F. G. ---------- Oshkosh
Crockett, W. W. ---------- Beloit
Crosby, E. P. ---------- Stevens Point
Cunningham, Wilson ---------- Platteville

Donohue, M. J. ---------- Antigo

Fazen, L. E. ---------- Racine
Folsom, W. H. ---------- Fond du Lac
Forkin, G. E. ---------- Menasha
Friend, L. J. ---------- Beloit

Gavin, S. E. ---------- Fond du Lac
Grosskopf, E. C. ---------- Waukesha

Hammond, F. W. ---------- Manitowoc
Haubrick, H. J. ---------- Oshkosh
Heraty, J. E. ---------- La Crosse

Junck, J. A. ---------- Milwaukee

Kleinboehl, J. W. ---------- Mercer

Leonard, C. W. ---------- Fond du Lac
Linn, W. N. ---------- Oshkosh
Lockhart, C. W. ---------- Mellen
Lockhart, J. W. ---------- Oshkosh
Ludden, H. D. ---------- Mineral Point
Lumsden, William ---------- Menomonie
Lundmark, L. M. ---------- Ladysmith

Madison, J. D. ---------- Milwaukee
Marshall, V. F. ---------- Appleton
Meusel, H. H. ---------- Oshkosh

Nadeau, A. T. ---------- Marinette
Notbohm, W. R. ---------- Dousman

Peehn, F. G. ---------- Sturtevant
Pomainville, F. X. ---------- Wisconsin Rapids
Pope, F. W. ---------- Racine
Potter, R. P. ---------- Marshfield

Quick, E. W. ---------- Milwaukee

Radloff, A. C. ---------- Plymouth
Raymond, R. G. ---------- Brownsville

Schein, J. E. ---------- Oshkosh
Schmidt, E. S. ---------- Green Bay
Schmit, Louis ---------- Milwaukee
Schroeder, H. F. ---------- Marinette
Smith, S. M. B. ---------- Wausau

Tasche, C. T. ---------- Sheboygan
Thomas, W. O. ---------- Clinton
Twohig, D. J. ---------- Fond du Lac

Webb, E. P. ---------- Beaver Dam
Wheeler, W. P. ---------- Oshkosh
Witcpalek, W. W. ---------- Kewaunee

CONTINUATION COURSES SCHEDULED AT UNIVERSITY OF MINNESOTA

The University of Minnesota has announced the following continuation courses to be held at the Center for Continuation Study during the first part of 1955:

January 31–February 4—Courses in ophthalmology and otolaryngology for specialists in those fields. Physicians may register for one or both courses. Guest speakers in ophthalmology include Dr. P. J. Leinfelder, Professor of Ophthalmology, Iowa State University, Iowa City, Iowa, and Dr. Frank Newell, Associate Professor of Ophthalmology, Northwestern University Medical School, Chicago. In the otolaryngology course, speakers include Dr. Howard House, Associate Professor of Otolaryngology, University of Southern California, Los Angeles, and Dr. Peter Pastore, Professor of Otolaryngology, Rhinology, and Laryngology, University of Virginia Medical College, Richmond, Virginia.

February 14–16—Recent Advances in Internal Medicine. The course will deal with various aspects of hematology, cardiology, endocrinology, and respiratory physiology.

February 17–19—Cancer Detection for General Physicians. This course is presented jointly by the University of Minnesota and the Minnesota Division of the American Cancer Society and will consist of a series of lectures and informal discussions concerning cancer detection technics. Those wishing to observe and participate in certain examination procedures will be given an opportunity to do so.

February 28–March 2—Clinical Hematology. Registrants will be provided with slides for study showing examples of various blood cell types and of the more frequent hematological diseases. Lectures will include discussions of the anemias, the leukemias, and coagulation defects.

Constitution and By-Laws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

SEC. 3. Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the perquisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member, providing that the member continues in good standing in his local county medical society.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the By-Laws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and By-Laws. It shall consist of the councilors and the immediate past president. The president, the president-elect, the secretary, the treasurer and the speaker of the House of Delegates shall be ex officio members of the Council, but without the right to vote. Nine of its members shall constitute a quorum.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treas-

* As amended by the 1954 House of Delegates.

urer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

SEC. 2. The officers, except the councilors, shall be elected annually. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a by-law, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BY-LAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society, shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the By-Laws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. The Council shall establish rules relating to requiring written papers of speakers. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each fifty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

The term "full-paid members," as used in this section, includes regular members of the Society, life members, affiliate members, associate members, educational members, and members whose dues are waived or remitted by official action of the Society. Special service members, resident members, partial-pay members, and members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates

at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society twenty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the

treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The Secretary shall maintain certified copies of each component county society's constitution and by-laws, together with any amendments to the same.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet on the day preceding the annual session, and daily *if necessary* during the session and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings. or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and By-Laws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members to be known as a Committee on Auditing and Finance, shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council in January of each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer.

SEC. 7. The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

A Council on Scientific Work.
A Council on Medical Service.
A Committee on Public Policy.
A Committee on Grievances.

A Committee on Medical Education and Hospitals.
A Committee Advisory to the Woman's Auxiliary.
A Committee on Hospital Relations.
A Committee on Cancer.

Unless otherwise provided in these By-Laws, each of these committees shall consist of five members, each of whom shall serve for a term of five years. One member of each of these committees shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee the original appointments shall be for terms of one, two, three, four, and five years, and thereafter for terms of five years each.

SEC. 2. The Council on Scientific Work shall consist of five members, and each member shall serve for a period of five years. The Council on Scientific Work shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

SEC. 3. The Council on Medical Service shall consist of nine members appointed by the president of the Society. Appointments shall be so made that the terms of one-third of the members expire each year. The Council on Medical Service shall act to correlate activities of the Society in medical economic fields, and to inform the profession and the public of proposed changes affecting medical care in the state and the nation. It shall likewise study and suggest means for the improvement of the distribution of medical service to the public, and shall periodically inform county medical societies regarding its activities.

The Council shall direct the program of the Society in the field of public health education, and in such manner as is found suitable, shall seek to further the health of those employed in Wisconsin industry, as well as to promote the health and safety of those engaged in rural Wisconsin.

SEC. 4. The Committee on Public Policy shall consist of five members, and the president, the president-elect and secretary. The committee shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

SEC. 5. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice. The committee shall possess similar responsibilities where request is made to investigate complaints bearing upon a member's alleged violation of any provision of the Medical Practice Act.

The committee shall consist of nine members and the terms of one-third of its members shall expire each year, with each member appointed for a term of three years.

SEC. 6. The Committee on Medical Education and Hospitals shall serve in this state for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

The deans of the two Medical Schools in Wisconsin shall be members of this Committee, in addition to those appointed annually.

SEC. 7. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 8. The Committee on Hospital Relations shall consist of six members, and each member shall serve for a period of three years. Of the original appointments, two members shall be appointed for a term of one year, two members for a term of two years, and two members for a term of three years, and thereafter for terms of three years each. The principal duty of this committee shall be to consider, investigate and study the interrelationship of the medical profession to the hospital institutions, and to act in an advisory capacity to the Society.

The Committee on Hospital Relations of the State Medical Society of Wisconsin is specifically charged with the responsibility of receiving and considering all complaints and/or queries from any physician, hospital, medical organization, or other interested person or group, relating to professional and/or economic problems occurring in the practice of medicine in hospitals wherein a dispute has arisen between a physician and a hospital. If the matter under consideration cannot be arbitrated by the good offices of the Committee on Hospital Relations, its findings to that effect shall be transmitted to the Council of the State Medical Society of Wisconsin with its findings and recommendations in order that the Council may then make suitable recommendations to the Judicial Council of the American Medical Association.

SEC. 9. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 10. The Wisconsin Medical Journal shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted on payment of $10 annual dues.

SEC. 5. *Educational Memberships:* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine. shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

SEC. 6. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 7. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and By-Laws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and by-laws shall have been submitted to the Council and received its approval.

SEC. 2. Only one component medical society shall be chartered in each county.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a bona fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and by-laws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the society.

A member of a component society whose license has been revoked or suspended shall be dropped from membership automatically as of the date of revocation or suspension. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and By-Laws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are

licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. Each component county society shall elect one or more delegates and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these By-Laws. The term of office shall be pursuant to the constitution and by-laws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

SEC. 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and by-laws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member until the month following his discharge from the armed forces of the United States, at which time he shall pay prorated dues for the balance of the calendar year of his discharge from service. Special service membership shall lapse at the close of the calendar year of the discharge of each such member from service.

CHAPTER XII

SECTION ON MEDICAL HISTORY

Membership in this Section shall be composed of those interested in preserving medical history in Wisconsin. The Section shall have the power to elect its chairman and other officers, and the office of the secretary of the State Medical Society shall provide secretarial assistance to it.

Annual dues shall be fixed by the Section and shall not exceed $10 per year. The Section is empowered to accept contributions to its projects and may solicit funds in behalf of the Society. All funds of the Section shall be segregated, and expenditures from them shall be made under direction and supervision of the Section, subject to approval of the Council.

Special membership certificates may be issued to those who become members of the Section, and displays may be developed by the Section for exhibit at the Society's Annual Meeting and elsewhere.

CHAPTER XIII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with

the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIV

SECTION 1. These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these By-Laws, all previous Constitutions and By-Laws are thereby repealed.

ARE YOU USING THESE GUIDES?

The divisions, committees, and councils of the State Medical Society of Wisconsin, in cooperation with various voluntary and governmental agencies, have been responsible for the development of numerous guides and manuals related to certain aspects of medical practice. While these have been made available to every member, it is quite possible they may not be at hand when the occasion arises for their use.

The following guides and manuals are available upon request to the State Medical Society office:

1. **Adoption Procedures in Wisconsin**—A reminder of statutes governing adoption proceedings and a guide to agencies serving the unwed mother or married parents seeking to place a child for adoption.
2. **Civil Defense Manual for Mobile Medical Team Personnel**—An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.
3. **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.
4. **Ethical Practices in Reference to Workmen's Compensation and the "Open Panel Program"**—A guide for the use of physicians, industrial nurses, management and insurance carriers in handling consultation, reports, complaints, and free choice of physician in relation to the compensation program.
5. **Guide for the Development of a Local or Regional Rheumatic Fever Program**—Recommendations for a model plan of rheumatic fever program emphasizing the convalescent home, diagnostic and follow-up clinics, and a home-service program.
6. **Hearing Conservation Programs for Wisconsin Industries**—Some recommended standards and principles for providing a hearing conservation program in industry.
7. **Industrial Health, A Guide for Medical and Nursing Personnel**—General principles and suggested procedures for an industrial health program, especially in relation to standing orders for nurses.
8. **Medical Care of Migrant Agricultural Workers**—A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.
9. **Membership Manual of the State Medical Society of Wisconsin**—A manual on membership and dues problems of the State Medical Society and the American Medical Association. Primarily for the assistance of county medical society officers.
10. **Minimum Standards of Medical Care for County Hospitals**—A guide to physicians and county asylum superintendents concerning medical care for patients in county hospitals.
11. **Participation by Physicians in Radio and Television Programs**—A guide to physicians and county medical societies for their presentation of or participation in radio and television programs.
12. **Planning Your Career as a Medical Associate**—A brochure to acquaint young people with the careers open to them in fields related to medicine.
13. **School Health Examinations**—A guide for physicians and school authorities in establishing a program of school health examinations.
14. **School Vision Screening Program**—An outline to facilitate the development of a program to detect significant visual defects among school children.
15. **Standards for Management Services Desiring to Advertise in the Wisconsin Medical Journal**—A list of standards under which the Wisconsin Medical Journal will accept advertising on behalf of management services for physicians.
16. **Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers**—A list of the objectives of the State Medical Society in devising the Wisconsin Plan and the conditions under which insurance carriers may participate in that plan.
17. **Wisconsin Physicians Service Manual**—A guide for physicians and their office assistants in servicing contracts held by subscribers to the Blue Shield Plan of the State Medical Society of Wisconsin.
18. **Wisconsin Veterans Medical Service Agency Schedule of Fees**—A description of the Wisconsin Veterans Medical Service Agency of the State Medical Society, instructions on arranging "home-town" care for veterans with service-connected disabilities, and the schedule of fees negotiated with the Veterans Administration.

Facts about

"THE DOCTORS' PLAN"

THE BLUE SHIELD PLAN
OF THE
STATE MEDICAL SOCIETY OF WISCONS

WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON PREPAID PLANS

Charting the Course for Blue Shield*

"If our profession feels that in having launched and established the Blue Shield movement it has now done its bit for progress, and the situation must be frozen as it is, then it is merely forging tomorrow's reaction from today's advance. There is a continuing need for improvement, adjustment and leadership in this area . . .

"*It is time that medicine seize the initiative* in matters so vitally affecting all of the public and offer what is needed before it is demanded. Those who have played chess know the advantage of the move. Other things being equal, the player having the first move should win. I feel this is equally applicable to our public relations, for answering or countering is never as effective as moving first . . .

"The country has seen that prepayment of sickness costs can be made to work and that a high degree of satisfaction can be enjoyed by the consumer and provider of services, with confidence in the agent. It has seen that business principles can operate with a minimum of disturbance between the individual doctor and the individual patient. The public has found that comprehensiveness of coverage, a thing it desires, can be offered to a considerably greater extent than cautious planners at first believed to be fiscally sound. It appears to accept in good faith a reasonable number of overuse controls, when it is shown the distinct premium saving resulting . . .

"It is my belief that a realistic extension of coverage is the right of the consumer. It is certainly the desire of the consumer. It is the duty of the profession, through its Blue Shield, to afford protection to a degree that does not leave the insured in doubt as to the value of his coverage. It is also the duty of the profession, through its Blue Shield or its medical associations, to acquaint the people with the true value of medical services, so that a fair fee for a service rendered is understood by the person paying for it. To me, a fair fee is a proper fee, whether paid directly by patient to doctor, or via an insurance plan or Blue Shield. An informed public will appreciate the direct relationship between premium charged and a realistic return to the physician for effort expended. As a practicing physician, I desire to state that I reject the argument that Blue Shield payment to the physician should be less because of the greater certainty of collection.

"The needs, and desires, of each area vary, but the trend is toward greater coverage. It is uneconomical to insure against cats-and-dogs types of risks, but the people want a reasonable sense of security, and I feel they should be given their right to purchase it.

"Of rapidly increasing importance is the role that national contracts will play in Blue Shield's future . . . More and more industries are writing contracts to cover their employees in all states, and they are puzzled and frustrated when they find countless obstacles in their path. More and more, it will become essential that Blue Shield plans reach agreement as to uniformity of action in such cases . . . National organizations *want* to deal with Blue Shield. If we are to satisfy them, we must cut across local concepts and often compromise on numerous points in order that our composite whole be one of working unity rather than conglomerate, ineffectual confusion. We must learn to conceive of National Blue Shield as being a coordinating agency, acting for us, so that we can be more than locally effective . . ."

*Excerpts from an address before the annual meeting of the Medical Service Bureau of the Utah State Medical Association, Inc., by Francis T. Hodges, M. D., President, California Physicians' Service.

For Information or Advice

Write • 704 E. GORHAM ST., MADISON, WIS. Phone • 6-3101 MADISON, WIS

Dramamine's® Effect in Vertigo

Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.

Vertigo, according to Swartout, is primarily due* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

Any of these conditions in which Dramamine is effective may be classed as "disease or abnormal stimuli"* of the tissues including the end organs (gastrointestinal tract, eyes) and their nerve pathways to the labyrinth.

Dramamine (brand of dimenhydrinate) is supplied in tablets of 50 mg. and liquid (12.5 mg. in each 4 cc.). It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

The site of Dramamine's action is probably in the labyrinthine structure.

*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.

Principles of Medical Ethics of the American Medical Association

PREAMBLE

These principles are intended to serve the physician as a guide to ethical conduct as he strives to accomplish his prime purpose of serving the common good and improving the health of mankind. They provide a sound basis for solution of many of the problems which arise in his relationship with patients, with other physicians, and with the public. They are not immutable laws to govern the physician. The ethical practitioner needs no such laws; rather they are standards by which he may determine the propriety of his own conduct. Undoubtedly, interpretation of these principles by an appropriate authority will be required at times; as a rule, however, the physician who is capable, honest, decent, courteous, vigilant, and an observer of the Golden Rule, and who conducts his affairs in the light of his own conscientious interpretation of these principles will find no difficulty in the discharge of his professional obligations.

CHAPTER 1

GENERAL PRINCIPLES

CHARACTER OF THE PHYSICIAN

SECTION 1.—The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals. A physician should be "an upright man, instructed in the art of healing." He must keep himself pure in character and be diligent and conscentious in caring for the sick. As was said by Hippocrates, "He shall also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

THE PHYSICIAN'S RESPONSIBILITY

SEC. 2.—The avowed objective of the profession of medicine is the common good of mankind. Physicians faithful to the ancient tenets of this profession are ever cognizant of the fact that they are trustees of medical knowledge and skill and that they must dispense the benefits of their special attainments in medicine to all who need them. Physicians dedicate their lives to the alleviation of suffering, to the enhancement and prolongation of life, and to the destinies of humanity. They share whatever they have learned and whatever they may discover with their colleagues in every part of the globe. They recognize instinctively that the need of improvement of medical knowledge and skills is never at an end, and while they strive toward satisfaction of this need they are zealous in making available to physicians of good character who possess the desire and the ability to learn the aggregate of progress in medical education, research, and discoveries as they may exist at the time. They do not remain content to limit their activities to the care of the infirm, since they recognize also their useful rank among the vast concourse of citizens on whose shoulders the destiny of our nation rests. At the same time they will resist attempts to debase their services by diverting them to ignoble purposes. In their relationship with patients, with colleagues, and with the public, they maintain under God, as they have down the ages, the most inflexible standards of personal honor.

GROUPS AND CLINICS

SEC. 3.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

ADVERTISING

SEC. 4.—Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

EDUCATION INFORMATION NOT ADVERTISING

SEC. 5.—Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by publishers, motion picture producers or radio officials. These may offer to the physician opportunity to release to the public some article, exhibit or drawing. Refusal to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self seeking or solicitation. In such circumstances the physician should be guided by the decision of official agencies established through component and constituent medical organizations.

A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society.

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome

of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

The promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

PAYMENT FOR PROFESSIONAL SERVICE

SEC. 6.—The ethical physician, engaged in the practice of medicine, limits the sources of his income received from professional activities to services rendered the patient. Remuneration received for such services should be in the form and amount specifically announced to the patient at the time the service is rendered or in the form of a subsequent statement.

Unethical methods of inducement to refer patients are devices employed in a system of patronage and reward. They are practiced only by unethical physicians and often utilize deception and coercion. They may consist of the division of a fee collected by one physician ostensibly for services rendered by him and divided with the referring physician or physicians or of receiving the entire fee in alternate cases.

When patients are referred by one physician to another, it is unethical for either physician to offer or to receive any inducement other than the quality of professional services. Included among unethical inducements are split fees, rebates, "kickbacks," discounts, loans, favors, gifts, and emoluments with or without the knowledge of the patient. Fee splitting violates the patient's trust that his physician will not exploit his dependence upon him and invites physicians to place the desire for profit above the opportunity to render appropriate medical service.

Billing procedures which tend to induce physicians to split fees are unethical. Combined billing by physicians may jeopardize the doctor–patient relationship by limiting the opportunity for understanding of the financial arrangement between the patient and each physician. It may provide opportunity for excessive fees and may interfere with free choice of consultants, which is contrary to the highest standards of medical care.

PATENTS AND COPYRIGHTS

SEC. 7.—A physician may patent surgical instruments, appliances and medicines or copyright publications, medicines and procedures. The use of such patents or copyrights or the receipt of remuneration from them which retards or inhibits research or restricts the benefits derivable therefrom is unethical.

OWNERSHIP OF DRUGSTORES AND DISPENSING OF DRUGS AND APPLIANCES BY PHYSICIANS

SEC. 8.—It is unethical for a physician to participate in the ownership of a drugstore in his medical practice area unless adequate drugstore facilities are otherwise unavailable. This inadequacy must be confirmed by his component medical society. The same principle applies to physicians who dispense drugs or appliances. In both instances, the practice is unethical if secrecy and coercion are employed or if financial interest is placed above the quality of medical care. On the other hand, sometimes it may be advisable and even necessary for physicians to provide certain appliances or remedies without profit which patients cannot procure from other sources.

REBATES AND COMMISSIONS

SEC. 9.—The acceptance of rebates on prescriptions and appliances or of commissions from those who aid in the care of patients is unethical.

SECRET REMEDIES

SEC. 10.—The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

EVASION OF LEGAL RESTRICTIONS

SEC. 11.—An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

CHAPTER II

DUTIES OF PHYSICIANS TO THEIR PATIENTS

STANDARDS, USEFULNESS, NONSECTARIANISM

SEC. 1.—In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end, he should not base his practice on an exclusive dogma or a sectarian system, for "sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought."* A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience. All voluntarily associated activities with cultists are unethical. A consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice.

PATIENCE, DELICACY AND SECRECY

SEC. 2.—Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

PROGNOSIS

SEC. 3.—The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

* Nicon, father of Galen.

THE PATIENT MUST NOT BE NEGLECTED

SEC. 4.—A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

CHAPTER III

DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSION AT LARGE

ARTICLE I.—DUTIES TO THE PROFESSION

UPHOLDING THE HONOR OF THE PROFESSION

SEC. 1.—A physician is expected to uphold the dignity and honor of his vocation.

MEMBERSHIP IN MEDICAL SOCIETIES

SEC. 2.—For the advancement of his profession, a physician should affiliate with medical societies and contribute of his time, energy and means so that these societies may represent the ideals of the profession.

SAFEGUARDING THE PROFESSION

SEC. 3.—Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education.

SEC. 4.—A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be considered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

ARTICLE II.—PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER

DEPENDENCE OF PHYSICIANS ON EACH OTHER

SEC. 1.—As a general rule, a physician should not attempt to treat members of his family or himself. Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity.

COMPENSATION FOR EXPENSES

SEC. 2.—When a physician from a distance is called to advise another physician about his own illness or about that of one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered him. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss may, in part at least, be provided for in the compensation offered.

ONE PHYSICIAN IN CHARGE

SEC. 3—When a physician or a member of his dependent family is seriously ill, he or his family should select one physician to take charge of the case. The family may ask the physician in charge to call in other physicians to act as consultants.

ARTICLE III.—DUTIES OF PHYSICIANS IN CONSULTATIONS

CONSULTATIONS SHOULD BE ENCOURAGED

SEC. 1.—In a case of serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

CONSULTATION FOR PATIENT'S BENEFIT

SEC. 2.—In every consultation, the benefit to the patient is of first importance. All physicians interested in the case should be candid with the patient, a member of his family or a responsible friend.

PUNCTUALITY

SEC. 3.—All physicians concerned in consultations should be punctual. When, however, one or more of the consultants are unavoidably delayed, the one who arrives first should wait for the others for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any other reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or it be the desire of the patient, his family or his responsible friends, the consultant may examine the patient and mail his written opinion, or see that it is delivered under seal to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

PATIENT REFERRED TO CONSULTANT

SEC. 4.—When a patient is sent to a consultant and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the results of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

DISCUSSIONS IN CONSULTATIONS

SEC. 5.—After the physicians called in consultation have completed their investigations, they and the physician in charge should meet by themselves to discuss the course to be followed. Statements should not be made nor should discussion take place in the presence of the patient, his family or his friends, unless all physicians concerned are present or unless all of them have consented to another arrangement.

RESPONSIBILITY OF ATTENDING PHYSICIAN

SEC. 6.—The physician in charge of the case is responsible for treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, after such a change, it is best to call another consultation; then the physician in charge should state his reasons for departing from the course decided

at the previous conference. When an emergency occurs during the absence of the physician in charge, a consultant may assume authority until the arrival of the physician in charge, but his authority should not extend further without the consent of the physician in charge.

CONFLICT OF OPINION

SEC. 7.—Should the physician in charge and a consultant be unable to agree in their view of a case, another consultant should be called or the differing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge.

CONSULTANT AND ATTENDANT

SEC. 8.—When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV.—DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

MISUNDERSTANDINGS TO BE AVOIDED

SEC. 1.—A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.

SOCIAL CALLS ON PATIENTS OF ANOTHER PHYSICIAN

SEC. 2.—When a physician makes social calls on another physician's patient he should avoid conversation about the patient's illness.

SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed.

CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in charge of a case, he should not disparage, by comment or insinuation, the one who preceded him. Such comment or insinuation tends to lower the confidence of the patient in the medical profession and so reacts against the patient, the profession and the critic.

EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.

PRECEDENCE WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as is practicable, or on the arrival of the acknowledged personal or family physician, the first physician should withdraw. Should the patient, his family or his responsible friend wish some one other than he who has been in charge of the case, the patient or his representative should advise the personal or family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital without the knowledge of the physician who is known to be the personal or family physician, the patient should be returned to the care of the personal or family physician as soon as is feasible.

A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during the colleague's temporary absence, or when, because of an emergency, a physician is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy that he would wish used in similar circumstances if the patient were his responsibility. The patient should be returned to the care of the attending physician as soon as possible.

SUBSTITUTION IN OBSTETRIC WORK

SEC. 8.—When a physician attends a woman who is in labor because the one who was engaged to attend her is absent, the physician summoned in the emergency should relinquish the patient to the first engaged, on his arrival. The one in attendance is entitled to compensation for the professional services he may have rendered.

ARTICLE V.—DISPUTES BETWEEN PHYSICIANS

ARBITRATION

SEC. 1.—Whenever there arises between physicians a grave difference of opinion, or of interest, which cannot be promptly adjusted, the dispute should be referred for arbitration, preferably to an official body of a component society.

ARTICLE VI.—COMPENSATION

LIMITS OF GRATUITOUS SERVICE

SEC. 1.—Poverty of a patient, and the obligation of physicians to attend one another and the dependent members of the families of one another, should command the gratuitous services of a physician. Institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, should meet such costs as are covered by the contract under which the service is rendered.

CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care.

CONTRACT PRACTICE

SEC. 3.—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a

group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

FREE CHOICE OF PHYSICIAN

SEC. 4.—Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not *per se* cause a contract to be unethical. A third party has a valid interest when, by law or violation, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability.

COMMISSIONS

SEC. 5.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, the giving or receiving of a commission by whatever term it may be called or under any guise or pretext whatsoever is unethical.

PURVEYAL OF MEDICAL SERVICE

SEC. 6.—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

CHAPTER IV

THE DUTIES OF PHYSICIANS TO THE PUBLIC

PHYSICIANS AS CITIZENS

SEC. 1.—Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations.

PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic prevails, a physician must continue his labors without regard to the risk to his own health.

PHARMACISTS

SEC. 3.—Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharmacist in education of the public concerning the practice of ethical and scientific medicine.

FILM ON CLEFT PALATE CHILD AVAILABLE

A new movie, "The Wisconsin Cleft Palate Story," in sound and color, has been produced by the Bureau for Handicapped Children, Department of Public Instruction, in cooperation with the University of Wisconsin Medical School, Department of Speech, and University Hospitals. It shows the integration of services necessary in the habilitation of a cleft palate child. This 36-minute film tells the story effectively and honestly.

The film can be rented from the Bureau of Visual Instruction, University of Wisconsin, 1323 West Johnson Street, Madison, Wisconsin, for a nominal fee. It is available for purchase through the Photographic Laboratory, 1204 West Johnson Street, University of Wisconsin Extension Division, Madison, Wisconsin.

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MD'S IN MILWAUKEE AREA URGED TO ATTEND SCHOOL HEALTH CONFERENCE—FEBRUARY 10

On February 10 the third of a series of school health conferences will be held at Wisconsin College, Milwaukee, and all physicians in any way concerned with school health affairs are urged to attend and participate in the discussion. The program is under the immediate sponsorship of the Division on School Health, with E. H. Pawsat, M. D., Fond du Lac, chairman.

Headliners for the morning program will be Doctors E. S. Gordon and Thomas Lorenz of the University of Wisconsin Medical School, who will jointly discuss "The Integrated Physical and Mental Growth of Children."

During the afternoon a series of round table discussions will be held, with the following topics to be discussed:

1. **Health Examinations and Other School Health Services**

   A. *In Metropolitan Areas:*

   (G. F. Burgardt, M. D., Wauwatosa, and P. S. Pierson, M. D., Milwaukee, are panel members, while E. R. Krumbiegel, M. D., and F. J. Mellencamp, M. D., both of Milwaukee, are resource persons)

   B. *In Other Communities:*

   (P. B. Blanchard, M. D., Cedarburg, and A. H. Heidner, M. D., West Bend, are among the panel participants, while A. C. Edwards, city health officer in Racine, is a resource person)

2. **Special Health Problems (Nutrition, Dental Health, Diabetes, Rheumatic Fever, etc.)**

   (K. H. Beck, M. D., Wauwatosa, and S. F. Morgan, M. D., Milwaukee, are among the panel participants for this discussion)

3. **Putting Preventive Mental Health Concepts to Work in the School**

   (James Johnson, M. D., Milwaukee, will be a panel member, while J. R. Altmeyer, M. D., and Bernhard Kaufman, M. D., both of Milwaukee, will be resource persons)

4. **The Role of Parents, the MD or Dentist, and Others in Referral and Treatment of Pupils with Emotional Problems**

   (H. T. Schroeder, M. D., Racine, and Sara Geiger, M. D., Milwaukee, will be panel members)

5. **Health Aspects of Physical Education**

   (C. W. Dowding, M. D., Milwaukee, will be a panel member)

All MD's interested in attending are urged to write the Division on School Health, State Medical Society, Box 1109, Madison, for a complete program.

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Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

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** Then president of the University of Wisconsin and professor of zoology.

*** Centennial Award.

† Deceased.

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A. L. Castleman, Delafield 1855
John Mitchell, Janesville 1856
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E. S. Carr, Madison 1860, 1861
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(No meetings held from 1863 through 1866; apparently no new officers).

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THE WISCONSIN MEDICAL JOURNAL

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Volume 54 FEBRUARY 1955 Number 2

Indications For Cardiac Surgery*

By THOMAS J. E. O'NEILL, M. D.**
Philadelphia, Pa.

THE development in the past six years of technics of value in a variety of heart ailments has created a new area for surgical consideration, and the increasing application of these technics has narrowed the range of speculation about them.

Cardiac surgery includes operations on the valves, septa, and the walls of the chambers. Rheumatic fever, congenital and degenerative processes are the major causes of defects in these structures. Extracardiac vascular surgery for correction of patent ductus arteriosus, coarctation of aorta, anomalous vessels, and the like is not properly classified as heart surgery.

Most important for a successful outcome is correct diagnosis. New diagnostic methods permit a high degree of accuracy in determining the location of the lesions, their size, composition, and relation to surrounding tissues. The status of the myocardium can be determined by the electrocardiograph. Catheterization studies and x-ray visualizations with contrast media give information about stresses and shunts not otherwise obtainable.

Another important factor is the age of the patient. The extremes of age introduce additional problems that influence the outcome and require modification of technics.

Complications of the cardiac disorder itself and of other diseases change the prognosis. The probable outcomes with and without surgery must be carefully weighed.

Cardiac lesions considered operable are: mitral stenosis, pulmonic stenosis, aortic stenosis, tricuspid stenosis, mitral insufficiency, aortic insufficiency, atrial septal defect, ventricular septal defect, coronary thrombosis, angina pectoris, and certain combined lesions.

* * *

Mitral stenosis is usually due to rheumatic infection. The five recognizable stages of the disease are: (1) asymptomatic; (2) statically incapacitating; (3) progressively incapacitating; (4) terminally incapacitating; and (5) irretrievable. Each represents a definite grade of severity and presupposes that a state of "pure" stenosis is present.

The history is often characteristic. Dyspnea is always the initiating symptom of the disease and is usually followed by fatigue, palpitation, hemoptysis, cyanosis, and orthopnea of moderate degree. Emboli may occur, and occasionally there is edema of the ankles and liver.

Accentuation of the mitral first sound and pulmonic second sound, a diastolic rumble and a systolic murmur of low intensity at the apex are heard. The heart is usually enlarged, and there may be signs of congestive failure. With progression of the disease, sinus rhythm is replaced by auricular fibrillation. The blood pressure is normal or low in the extremities.

The electrocardiogram generally shows right axis deviation but, at times, may show no deviation. The cardiac x-ray will show enlargement of the right ventricle, the left atrium, the pulmonary artery conus and distal vessels. The left ventricle and right atrium are not enlarged. The lungs may be congested, and calcification in the valves can be visualized fluoroscopically when present.

Cardiac catheterization usually reveals pulmonary hypertension. Normally, it is not

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*Presented at the One Hundred and Thirteenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 6, 1954.

**Assistant Clinical Professor of Surgery, Woman's Medical College of Pennsylvania. From the Department of Thoracic Surgery at Episcopal, Presbyterian, Hospital of the Woman's Medical College, Abington and Frankford hospitals, Philadelphia, Pennsylvania.

necessary to catheterize the patient for confirmation. Angiocardiograms will show a delay in emptying of the left atrium for periods up to 30 seconds.

The myocardium of the left ventricle may be normal, fibrosed, or hypertrophied, although it is usually atonic. Rheumatic inflammation of the myocardium may be present and may lead directly to left ventricular failure. The atrium is usually overstretched, edematous, and fibrosed.

The pulmonary artery pressures are not always related to the severity of the symptoms but do influence postoperative convalescence. Prolonged pulmonary hypertension will lead to fibrosis of the arterioles and diminish the value of operation. Because of myocardial fibrosis, the heart chamber size may be so fixed that reduction in intrachamber pressure will not change the ultimate heart size. Also, when auricular fibrillation is well established, there is small opportunity of conversion to sinus rhythm.

The age of the 600 patients we have successfully operated on ranged from 4 years to 61 years. The best results were achieved in those in the third and fourth decades. Those of the extreme ages show no greater operative mortality but are usually less benefited by surgery.

If valve leaflets are pliable, there will be good functional restoration. Heavily calcified valves, even when adequately opened, usually present poor movement. If the stenotic orifice is located eccentrically, the results are generally poorer. In perhaps 1 per cent of patients there will be found internal concentric hypertrophy of the left ventricle which, in itself, will have the same effect as stenosis, aside from the condition of the valve. Calcification or severe fibrosis of the left atrium usually limits the operative access to the valve.

Complications which will limit the functional result are auricular fibrillation, intracardiac thrombosis, lung infarction or fibrosis, peripheral emboli, myocardial fibrosis, cor bovinum, and other concomitant local or systemic disease.

The probable prognosis of severe mitral stenosis not treated by surgery is a continuation of symptoms and disabilities through the above gradation of the five stages of the disease, eventuating in premature death. Mitral stenosis treated by surgical means results in improvement in 75 per cent of the cases; in 25 per cent of those improved the surgery is regarded as curative. The operative mortality is 7 per cent, and the late mortality is 8 per cent. The expected associated results are the prevention of emboli, hemoptysis, pulmonary edema, and heart failure. If the surgery is done early, auricular fibrillation is usually prevented, and improvement in exercise tolerance will be seen. Objective pulmonary artery pressures usually descend to normal levels; and in a number of instances, the heart size is reduced.

The present operative technics can be considered adequate, and it is probable that any future improvements will be negligible. The indications for operative intervention are the presence of mitral stenosis with any or all of the symptoms and signs enumerated above. The absolute contraindications are active rheumatic fever and bacterial endocarditis.

* * *

Pulmonic Stenosis. The incidence of solitary pulmonic stenosis is much higher than previously suspected and is now more frequently recognized because the signs and symptoms are more widely publicized. It is about one-fourth as common as tetralogy of Fallot. The disease almost always results from a congenital defect.

The diagnosis is made from the history of dyspnea on exertion; mild to moderate polycythemia; impaired growth; and, occasionally, cyanosis. There may be clubbing of the fingers. At times there are no symptoms.

Physical examination will demonstrate a systolic murmur and thrill over the pulmonary artery area. The heart size is usually within normal limits. The second pulmonic sound is either diminished or absent. Sinus rhythm is the rule.

There is nothing unusual about the electrocardiogram, although right axis deviation may be present.

The myocardium of the right ventricle is usually subjected to strain; however, early failure is not commonly seen.

Abnormally high pressures in the right ventricle and low pressures in the pulmonary arterial bed can be demonstrated. There is a decrease in reserve so that exercise will result in a deficient blood flow to the lungs and decrease in oxygen saturation of the blood, thereby giving rise to the symptoms enumerated.

Because it is a congenital defect that causes a murmur, the diagnosis is made in early childhood. Symptoms develop from the increase in the disproportion between the pulmonic outflow area and the body growth of the child. Operative treatment is usually indicated at the time of diagnosis if symptoms are present or are likely to occur.

On radiological examination, the heart and lungs may appear normal; but usually there is some right ventricular enlargement, with diminution of lung arterial pattern. Frequently there is a dilatation of the pulmonary conus segment.

Cardiac catheterization should be done and will show elevation of pressures in the right ventricle and reduced pressure in the pulmonary artery because of the obstruction interposed. Probably the most significant feature will be the pressure gradient between the two locations. There may be a double gradient present if there is infundibular obstruction.

Angiocardiography will determine if atrial or ventricular shunts are present, will reinforce the diagnosis, and will show the location of the obstruction.

The obstructing mechanism is at the pulmonic valve alone in three-fourths of instances but may be located at the infundibular area. At times it may involve both locations. A histological picture of dense fibrosis without calcification is present.

Complications are few but serious. Right heart failure may be persistent as a result of an overworked right ventricle. Associated deformitories such as atrial septal defects, ventricular septal defect (tetralogy of Fallot), and anomalous veins may complicate the physiology and are not always compensating defects. That obstruction to the pulmonary outflow is the most important factor is shown by the improvement that follows removal of the obstruction, even in the presence of these other defects.

Without surgery there is a progression of signs and symptoms leading to early death. Cure can be accomplished with surgery in nearly all cases. We have operated on 36 solitary pulmonic stenosis cases with no mortality and excellent results in all.

The present operative technics of closed surgery are relatively simple and are not likely to be improved upon.

Aortic Stenosis. Three types occur. The most common is rheumatic in origin, a less common type is arteriosclerotic, and a rare type is congenital. It may be hard to distinguish between the acquired types, although the latter carries the poorer prognosis.

The diagnosis is based on the history of dyspnea, fatigue, angina on effort, syncope, and pulmonary edema. There are also five recognizable stages of the disease based on severity of signs and symptoms. On examination there is found a systolic murmur and thrill over the sternum, transmitted to the neck; the heart is usually enlarged, and the brachial blood pressure is usually low with a narrow pulse pressure. The electrocardiogram usually shows a normal sinus rhythm and a left axis deviation. Tachycardia may be seen. Radiologically, the aortic knob may be normal to small in size; and the left ventricle is enlarged. It is helpful to perform cardiac catheterization on the left side; there is usually a high pressure in the left ventricle and a relatively low aortic pressure. Where the gradient is low, operation will be unavailing.

There is great hypertrophy and edema of the left ventricle and an accompanying poor elasticity. Often poor operative results are attributable to failure of this chamber postoperatively.

The low output from the left ventricle is due to stenosis. Exercise will produce a falling off in pressure within the aorta which, in turn, deprives the coronary arteries of sufficient pressure, thereby resulting in coronary insufficiency. Cerebral blood flow is also impaired in the same manner.

In children and young adults having symptoms, the operation should be done if left heart catheterization findings indicate a wide differential between ventricle and aorta. Those over 40 years of age will generally do poorly.

The valves of congenital stenosis are usually not calcified as are some of the rheumatic valves. In arteriosclerotic stenosis and most of the rheumatic stenoses, there is heavy calcification, and usually it is not possible to achieve more than partial restoration of valve function even though the dilatation and splitting of the stenosis shows immediate good results.

Principal complications are ventricular arrhythmias, coronary insufficiency, and myocardial failure, leading rapidly to death.

The patient usually does fairly well without surgery until the initial bout of failure; then the average life expectancy is less than one year. Surgery, on the other hand, holds promise of good results in 80 to 90 per cent of the congenital types and rheumatic types if undertaken before the onset of failure. Operation following this event is extremely hazardous and in many instances is not justified, being 80 per cent lethal.

It is obvious that the greatest advance in the treatment of this particular stenosis must come in the form of earlier diagnosis, with surgery being done before significant symptoms develop. The use of serial left heart catheterizations may form a rational basis for intervention.

* * *

Triscuspid Stenosis. This is the only stenotic valvular lesion that nearly always is associated with multivalvular disease. Its principal association is with mitral deformity, but it is frequently seen with aortic disease as well. Notwithstanding, with the great number of mitral commissurotomies performed, it is likely that 3 per cent to 6 per cent of these patients may now show evidence of tricuspid stenosis alone.

The diagnosis is difficult to make in many cases because of the masking effects of the mitral stenosis. Dyspnea, extreme fatigue, abnormal venous pulsations, and peripheral stasis with hepatomegaly are variously seen but are not pathognomonic. On examination, a diastolic murmur at the lower end of the sternum is often heard. The electrocardiogram is not significant. Radiologically, there is enlargement of the right atrium, and the pulmonary vessels are not usually congested. Right atrial catheterization will show a large A wave occurring at the time of atrial systole. Angiograms of the right atrium will demonstrate the location of obstruction by the increased retention of dye and may even outline the area of obstruction.

In so far as the blockage precedes the inflow to the right ventricle, there is no strain on either side.

The physiological disturbance is principally seen as venous stasis peripherally, although the diminished blood delivery to the heart greatly reduces the cardiac reserve. Thus, the lungs are also protected but at the expense of reduced cardiac output.

Since the diagnosis is usually made at or following the time of mitral valve surgery, the optimum age range for surgery is the same as that in mitral stenosis.

The diseased valve is usually thickened with fibrosis and does not contain much calcium. The myocardium of the right atrium is dilated, edematous, and fibrotic.

The main complication is invalidism as evidenced by the poor functional response to exercise.

Without surgery, there is probably no shortening of life span but rather a continuation of distressing symptoms. With surgery, the valve can be adequately opened with little or no risk since there is very little chance for operative accidents.

Present technics are very satisfactory for the solution of this problem.

* * *

Mitral Insufficiency. Incompetence of the mitral valve is usually thought to be due to rheumatic fever. Early in its development there may be few or no symptoms until the onset of left ventricular failure. Then, dyspnea of paroxysmal character, with associated debility, develops. The left ventricle has remarkable ability to compensate for a long time; but when failure occurs, the expected life span is about seven months.

Examination reveals a grade III or more, long, systolic murmur at the apex, transmitted to the axilla, with diminished or absent first sound. The pulmonic second sound is accentuated slightly. The electrocardiogram shows left axis deviation. Radiologically, there is enlargement of the right ventricle, left ventricle, and left atrium; the latter may be of aneurysmal proportions. Catheterization will establish the diagnosis, with attention directed toward the character of the capillary curves.

Anatomically, there is generally either loss of substance of the posterior leaflet or dilatation of the annulus. Physiologically, there is loss of left ventricular output as well as venous stasis in the lungs.

The left ventricular myocardium is not unlike that seen in aortic stenosis and is greatly hypertrophied.

Generally, patients with this disease do not live much beyond the fourth decade, and corrective surgery should be done prior to signs of failure.

Up to the present time, very few successful results have been obtained through surgery, although recent experimental procedures have been more promising than the previous resorts to pericardial grafts, pros-

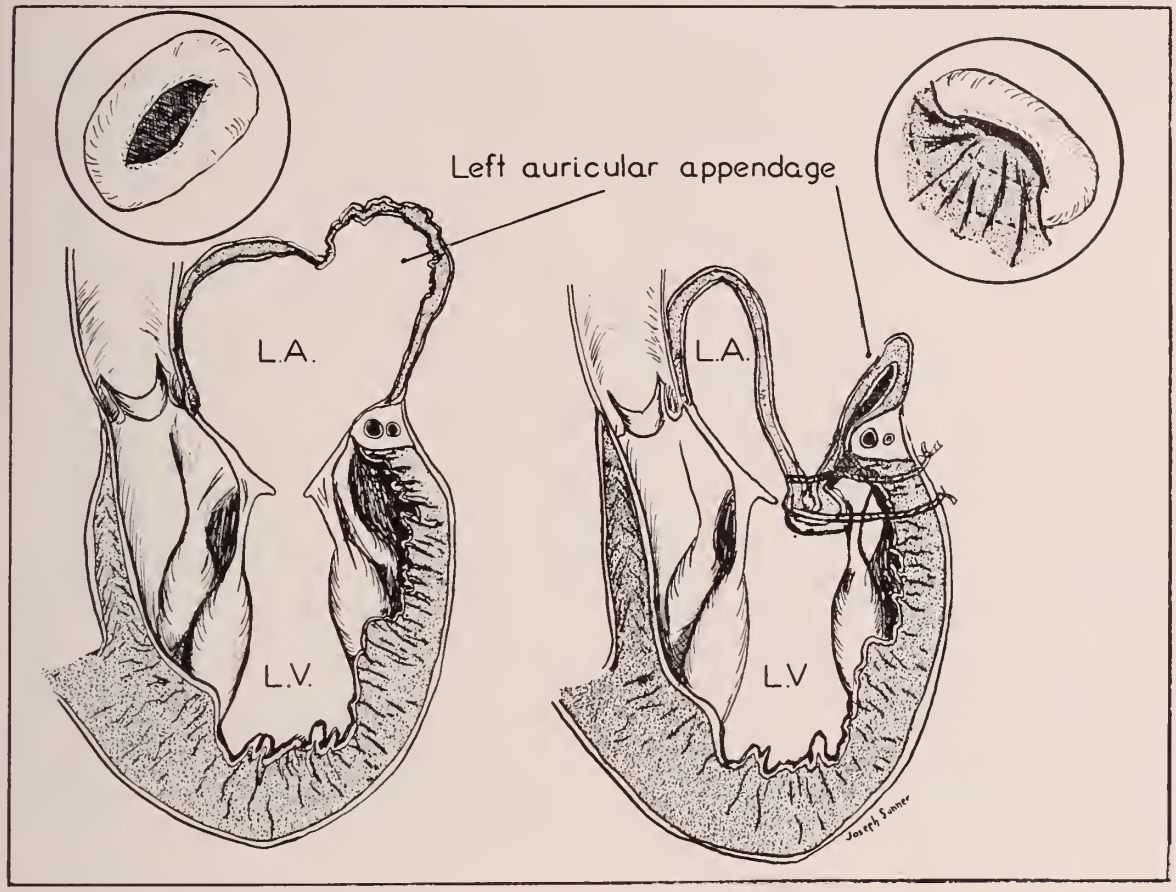

Fig. 1—Mitral insufficiency illustrated on the left. The insert on the left represents the degree of insufficiency during ventricular systole. The right hand figures and insert represent the building up of the posterior leaflet by invagination of the redundant left atrium.

theses, and the like. In our group there have been a few good results obtained by suturing the valve leaflets and also with the use of the left atrium itself for graft upon the deficient posterior leaflet. This has yet to be exploited fully and may render reasonably good results.

* * *

Aortic Insufficiency. Most often the insufficiency is a result of rheumatic infection. Occasionally, syphilis will be the causative factor. Differentiation is not too difficult.

The patient enjoys good health for long periods of time until the advent of failure, in spite of signs of aortic incompetency, characterized by palpitations of the heart and bounding neck vessels, as well as general pallor. As in stenosis, failure of the left ventricle heralds a precipitous downhill course without significant relief by medications. Dyspnea and anginal attacks are late symptoms. Examination usually shows an enlarged heart with aortic diastolic murmur, often accompanied by systolic murmur. The systolic pressure is elevated, and there is a very wide pulse pressure. The electrocardiogram shows a left ventricular preponderance.

Fluoriscopically, the left ventricle is enlarged; there is widening of the aorta, with marked expansile dilatation on systole. Intra-arterial pressure tracings are confirmatory.

Anatomically, either loss of valve leaflet area or an overstretching of the valve ring may be seen. Calcium deposition is common in the rheumatic types.

As the diastolic pressure in the aorta descends to that seen in the left ventricle, there is progressive increase in left ventricular strain. Coincidentally, the coronary artery circulation becomes impaired with the lowered diastolic pressure, which adds to the embarrassment of the ventricle. These forces combine in time to result in left ventricular failure. Terminally, there is fibrosis, edema, and dilatation of the myocardium.

Most deaths occur in the third to fifth decades, and the course is generally unaltered by medical therapy.

At present, the only possibility of hope is suggested by surgical implantation of an artificial aortic valve. For practical reasons, such a prosthesis is placed in the descending portion of the thoracic aorta and will provide a normal diastolic pressure distal to that point. This appears to reduce the strain on the left ventricle to the extent that the heart rate becomes lessened and the force quieter, and in some there is reduction in heart size. A sobering factor is the present high mortality incident to the operation, which in less favorable candidates will approximate 50 per cent. Earlier selection of patients for surgery may reduce this to a more acceptable figure.

* * *

Atrial Septal Defects. The simplest defect in the septum of the atria is patent foramen ovale; an anatomical communication exists between the two chambers but remains physiologically closed throughout life. This requires no consideration. Absolute or relative loss of tissue in the foramen ovale will permit shunting of the blood stream, usually from left to right, will eventually overload the lesser circulation and result in combined heart failure. The significance of the defect depends on its size. The primary ostium of the septum commonly persists. It is located adjacent to the combined annulus of the mitral and tricuspid valves. Often this defect is large and has a grave prognosis.

The usual initiating events are tachycardia and dyspnea on exertion. Bacterial endocarditis may intervene at any time. When right atrial pressure becomes elevated above the left atrial pressure, conduction defects are not uncommon.

In order to be certain of the diagnosis and to determine if other defects are present, it is necessary to perform cardiac catheterization. Typically, the catheter can be seen to pass across the atrial septum to the left side. Also, the oxygen saturation will be elevated in the vicinity of the defect. Radiologically, there is right atrial and ventricular enlargement and fullness of the pulmonary vascular shadows. A systolic murmur is usually heard at the base of the heart, but at times only a diastolic murmur can be heard.

The right atrium usually becomes dilated by the time the child is two or three years of age. Since this facilitates the performance of surgery, operation should be delayed until it has occurred. Further delay is not advisable.

The development of a new type of heart suturing instrument has greatly improved the technic of closure of these defects; in fact, it enables complete closure of three to five large ostium primum defects. Technical closure of the usually smaller secundum defects is no problem now. The overall results have been excellent.

* * *

Ventricular Septal Defect. Probably this is the most common congenital heart defect and is frequently associated with other malformations, especially pulmonic stenosis.

Singly, it is known as Roger's disease; but when associated with pulmonic stenosis, it is called tetralogy of Fallot. While the latter is more common, the currently accepted treatment is limited to by-pass or removal of the pulmonic obstruction alone.

Usually, the defect is located high in the septum and is astride the ventricular aspects of the aortic and pulmonic valves. This unfortunate location at present demands an elaborately complicated approach either by means of extracorporeal circulation or hypothermia.

An initial closure was accomplished by our group on January 9, 1952, in an adult patient who had a traumatic defect located in the lower area of the septum. Closure was complete as judged by the subsequent clinical and radiological course and supporting catheterization studies. Although the defect was closed with fascia lata, this would not be applicable in the usual congenital types because of the bulkiness of the repair material. The ideal operation appears to be direct vision suture-closure of the defect. This requires immobilization of heart action and concomitant protection of the brain through the use of general hypothermia or extracorporeal circulation.

The principal determent to this type of surgery is the uncertainty in the functioning of the equipment. Development in this direction will undoubtedly add improvement and refinements, assuring, in turn, a greater safety margin. One can expect an increasingly better prognosis in the surgical treatment of ventricular septal defect.

* * *

Anginal Pectoris and Coronary Artery Thrombosis. The degenerative changes in the coronary arteries and their branches account

Fig. 2—Closure of moderate-sized atrial septal defect. With the finger through the right auricular appendage, the special needle is introduced through the wall of the right atrium at any convenient point. Sutures are placed where necessary. The knots are tied through the small holes of the atrium at the point of needle penetration. A slight modification is used on larger defects.

for the largest number of heart ailments. An overall increase in human longevity will not be accompanied by either an actual or relative decrease in the incidence of this disease until the basic cause is elucidated and preventive measures can be employed.

The coronary veins do not share in the degenerative sclerotic process; this factor led Dr. Claude Beck to explore the possibilities of utilizing the veins as artificial pathways. Briefly, it is accomplished by rerouting aortic (oxygenated) blood into the collecting vein of the heart (coronary sinus) by direct anastomosis or interposed vessel graft. The normal flow is from the sinus into the right atrium; but when a severe stricture is produced at the atrial extremity, the blood flow will be directed to the capillaries which are common to both arteries and veins. Auxiliary venous drainage from the capillaries is adequately maintained through the sinusoids of the myocardium of the left ventricle. This operation is somewhat less than ideal because its performance is traumatic and time-consuming and requires two stagings. Furthermore, the shunt often does not remain patent, and so the primary intention is aborted.

One redeeming feature is that there develops some residuum of benefit of a secondary type thought to be an opening up of intercoronary arterial communications. The importance of this is apparent; many patients possess only end arteries in their coronary systems, and intercommunication would allow cross circulation at the important precapillary level, thereby protecting the entire myocardium from ischemia. At present, this operation probably should be limited to the younger and more vigorous patients who have persistent anginal attacks unrelieved by medications.

A less formidable approach and one available to the patient of more advanced years would be the application of an irritating mineral agent such as talc or asbestos to

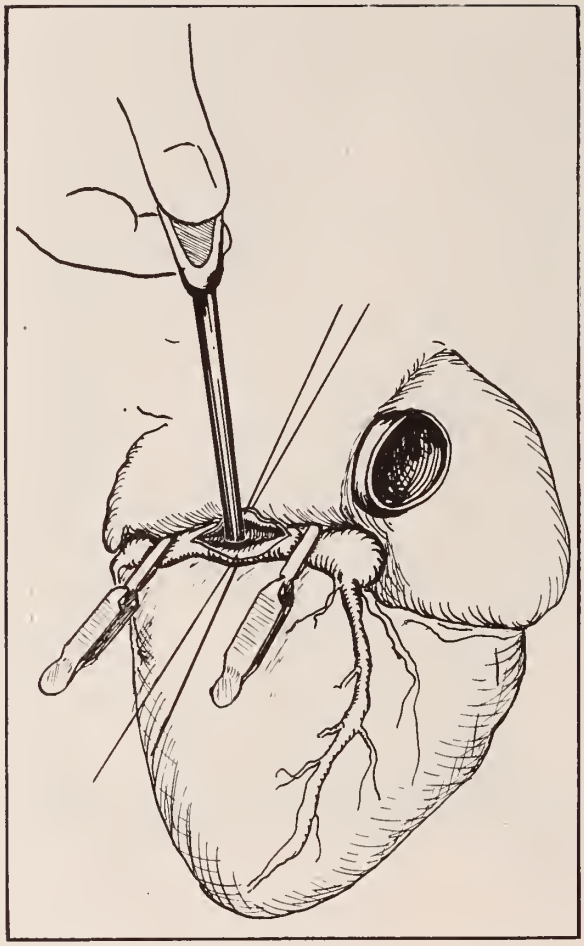

Fig. 3a—Creation of ventricular-sinus fistula. The illustration shows exposure of the termination segment of the coronary sinus. The sinus being clamped is incised, allowing a special trocar to be advanced beneath the annulus and mitral valve into the cavity of the left ventricle. The trocar carries a special flexible stainless steel spring tube which is placed to maintain a fistula.

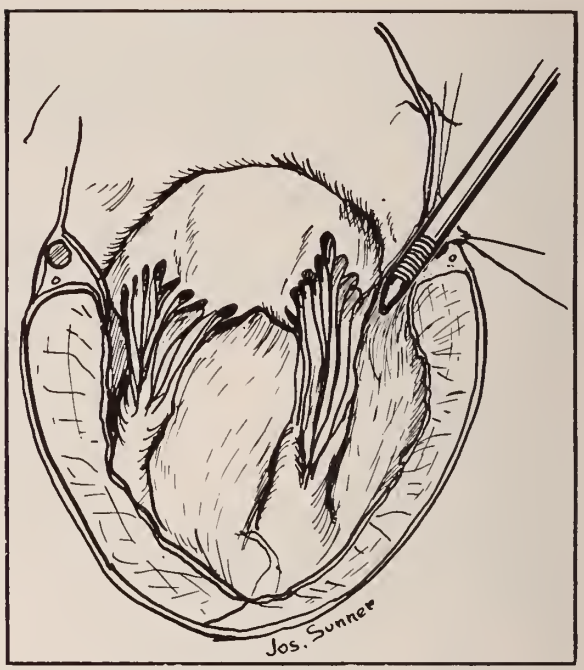

Fig. 3b—Creation of ventricular-sinus fistula. The illustration shows the position of the trocar and spring tube at the proper placement.

Fig. 3c—Creation of ventricular-sinus fistula. The illustration shows the tube in place, the wall of the sinus repaired, and the final situation of the shunt allowing blood flow from left ventricle to coronary sinus. In order to prevent progression of blood flow into the right atrium, a permanent ligature is placed to create a significant stricture.

the surface of the epicardium. This can be done rapidly through a small opening in the chest and will produce a dense network of adhesions which creates a collateral blood supply from the surrounding mediastinal vessels. Most reports, including our own, suggest 80 to 90 per cent relief of anginal attacks, and the mortality rate is low.

A suggested modification of the Beck procedure evolved from dog experimentation. A direct shunt was created between the left ventricle and coronary sinus in five human patients. Four of these showed excellent results. Again, this technic is presently difficult but may be modified in the future.

In conclusion, it is seen that a potentially vast new surgical field has been opened during the past several years, providing cure for many types of defects and amelioration for others. It is probable, in the light of recent experimental data, that in the near future, reasonable solutions will be found for the unsolvable problems of the moment.

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269 South 19th Street.

Erythroblastosis Fetalis

An Analysis of 66 Cases*

By HORACE K. TENNEY III, M. D.
Madison

Introduction

ERYTHROBLASTOSIS fetalis is a disease affecting about one in every 200 newborn infants or about one in every 20 infants born to Rh negative mothers.[1] It is due to incompatibility between the blood of the mother and that of the fetus, causing hemolysis of the baby's cells. As yet no method of prevention has been discovered, but by prompt treatment of the infant the mortality can be lowered. One of the most necessary matters in the control of the disease is an increased awareness of the disease. This necessitates antepartum Rh tests of all mothers and antibody titrations on many of those found to be Rh negative.

The series reported in this paper consists of all the cases of erythroblastosis seen at the University Hospitals, Madison, from 1945 through 1952. The majority of the 66 cases which make up this series were referred from various parts of the state, the remainder being born at this hospital. No attempt has been made to determine the exact incidence of the disease since the sample is not representative of the population as a whole. The cases have been analyzed from various standpoints such as laboratory findings, mother's history, treatment, and the findings presented.

First Children

It is well established that erythroblastosis fetalis is found much more frequently after the first pregnancy since time is required for immunization to occur.[2] However, there was one case in this series in which the mother's first baby was affected with erythroblastosis. In this instance the mother had received a transfusion of Rh positive blood in 1949, following surgery for a bowel obstruction. The baby, born three years later, was not admitted to this hospital until the eighteenth day of life, which was too late for an exchange transfusion. The baby recovered but in recent follow-up visits has been found to have some of the residuals of kernicterus.

There were three other cases in which the mother's history indicated that her first baby developed the symptoms of erythroblastosis. Two of these babies were jaundiced within the first day, and one was hydropic. The mother of the latter had been transfused. These case are not included, however, since the infants were not seen at this hospital and the diagnosis was not established.

Transfused Mothers

Thirteen of the case records gave an indication that the mother had been questioned about her history of transfusions, and eight of the mothers had received blood at some time in their lives. The babies of two of these mothers died, and two others are still living but have signs and symptoms of kernicterus. All but one of the transfusions given to this group of mothers were after 1943; and, therefore, appropriate typing should have been possible, since the Rh factor was discovered in 1940. After studying the records, it is believed that in only one case did the transfusion not contribute to the immunization of the mother. In this case the mother had lost six babies and was probably immunized before she was transfused. Therefore, almost all of these cases could have been prevented by proper Rh tests of the donor and recipient. At least one of the mothers received the husband's blood, which is certainly the best way of immunizing her to the Rh factor or to any other antigen that the husband might possess and pass on to his children.

History of Previously Affected Baby

In 21 of the cases, questioning of the parents revealed that the mother had had another baby with proved or suspected erythroblastosis. A few of these babies had been seen and diagnosed at this hospital, but the majority had been born elsewhere. The history had to be very suggestive of the disease before it was accepted—early jaundice in

* From the Department of Pediatrics, University of Wisconsin Medical School.

more than one baby; elevated anti-Rh titer in the mother's blood before delivery; or definite diagnosis by the attending physician, clinically or by postmortem examination. The mortality of these 21 babies was much higher than the general mortality of 24.2 per cent for the group as a whole. Two of the babies were stillborn; and of the remaining 19, seven died, giving a mortality of 37 per cent. Among this group of mothers, 14 gave a history of having lost babies from erythroblastosis before. The mortality here was 50 per cent. Even exchange transfusions had little effect; four of the eight babies that received them died.

The incidence of kernicterus has been said to be higher in those mothers who have already had one child with that complication.[3] We could not arrive at any statistics along this line since none of our mothers gave such a history. However, out of this group of 19 cases whose mothers had had previously affected babies, 4 (21 per cent) did develop kernicterus; this is a somewhat higher incidence than that for the whole series—14 per cent (9 cases out of the 66 studied).

Antibody Titers

The literature on antibody levels in mothers of erythroblastic infants is often confusing because of the different names applied to the antibodies. At the risk of becoming more confusing, but in the hope of clarifying matters, this paper will use the terminology of Mollison, Mourant, and Race,[4] which is based on the diluent used for making the tests. Agglutinins, mature or complete antibodies will be called saline antibodies; agglutinoids, immature or incomplete antibodies will be called albumin antibodies; and cryptagglutinoids or third order antibodies will be termed Coombs' antibodies because their detection involves the use of the indirect Coombs' test. If no designation is given, one assumes that the reference is to the albumen antibodies, since they are the ones found most frequently.

Antibody levels were done in only 42 of the 66 cases in this series, and most of these were done in the later years of the study. The range of albumin antibodies on the 13 patients that died was from 1:4 to 1:8192, with an average titer of 1:100. Coombs' antibodies were found in only four cases, with an average titer of 1:416. No cases with saline antibodies were reported. In the 29 cases that survived, there were 23 determinations of albumin antibodies, with a range of 0 to 1:512, and an average level of 1:14. Four cases of Coombs' antibodies had an average titer of 1:590, and the three examples of saline antibodies averaged 1:86. Thus, in taking the largest group, the albumin antibodies, it is seen that the average titer in the survivors (1:14) was much lower than in those who died (1:100).

Coombs' Test

Probably the most important laboratory procedure in the diagnosis of erythroblastosis is the Coombs' or developing test.[5] Since many babies born with this disease appear to be normal at birth and since treatment must be started early if it is to be effective, this test is invaluable in diagnosing the condition early before symptoms are present.

The serum used in performing the test is made by injecting human globulin into a rabbit and allowing the rabbit to build up antibodies against the globulin. The serum obtained in this way is the Coombs' serum or antihuman globulin rabbit serum and has a special affinity for human globulin. The technic of the test is to obtain one or two drops of the baby's blood and suspend the cells in saline. The cells must then be washed well three times to remove any free globulin that is present. After washing, they are resuspended in a small amount of saline, and the Coombs' serum is added. Since the Coombs' serum has an affinity for human globulin, it will attract that material; and if the globulin is adherent to the red blood cells, the serum will draw the cells together into a clump and the Coombs' test will be positive. Thus, a positive Coombs' test tells us that there is globulin adherent to the red blood cells of the baby; and since antibodies are made of globulin and the material could not be washed off, it is assumed that the globulin is attached to the cell by an antigen-antibody reaction. Since erythroblastosis is the only disease of newborn infants where antibodies are attached to the red blood cells, the diagnosis is made. If the test is negative and has been done correctly, one can almost assume, with a few exceptions, that the baby does not have erythroblastosis. False negative tests might result from:

1. Improper technic, especially incomplete washing of the cells.

2. Immunization due to an antigen other than the common Rh antigen (the D antigen). It is believed by some that a negative Coombs' test is obtained in cases where the immunization is due to the A or B factor.[6]
3. Applying the test late in the disease—it may be negative by the fifth or sixth day after the birth of an infant.

In this series the Coombs' test was done in 27 cases and was positive in 20. In three of the seven cases in which results were negative, the tests were done late in the course of the disease—at ages 14, 18, and 30 days—when one would almost expect negative results. In one of the four other cases the disease was caused by immunization to the A factor; in another the disease was so mild as to be almost nonexistent, but the case is included because an exchange transfusion was done. The two other negative Coombs' tests were in twins whose cases were in many aspects not typical of the disease.

No indication of severity could be obtained from this series since the strength of the Coombs' reaction was not given in most instances. In general, there may be a relationship between a strongly positive Coombs' test and severe disease in the baby.

Exchange Transfusion

The first exchange transfusion done at this hospital for the treatment of erythroblastosis was in March 1947. The subject of this procedure was a 36-hour-old infant who was very jaundiced and lethargic and whose mother had lost two previous children with erythroblastosis. Two hundred and seven cubic centimeters of blood was given via the saphenous vein. In spite of the treatment the baby developed kernicterus and died on the third day. This was a discouraging beginning since this method of therapy is aimed at preventing kernicterus. Since then we have learned that in order to be of maximum benefit, the treatment must be given within the first six to eight hours of life. The method of exchange transfusion that has been used in the last few years is that of Diamond;[7] this method employs a polyethylene catheter in the umbilical vein through which the blood is given and withdrawn.

Between 1947 and 1952, there were 22 babies who received exchange transfusions, and six of these died—a gross mortality of 27 per cent. This is only slightly different from the 24 per cent general mortality; but when the mortality rate before the advent of exchange transfusion is compared to that after, there is found to be a drop from 45 per cent to 20 per cent. Of the six babies who died, three were in very poor condition when the transfusion was begun and died before it could be completed. Two others received the transfusion late in the disease, one (referred to above) at 36 hours of age and another at 24 hours of age. The sixth death was that of a baby who had one exchange transfusion at 1¼ hours of age and two others following this and still failed to survive. The mother of this child had lost the previous five children, probably from erythroblastosis, and had an antibody titer of 1:8192 shortly after delivery.

Since exchange transfusion is aimed at preventing kernicterus, a few statistics along that line are in order. There were 9 cases of the disease in this group of 66 infants—3 proved by autopsy, 2 in which the infants died with the symptoms of the disease but had no postmortem examination, and 4 in which the babies lived and now exhibit signs and symptoms of kernicterus. Exchange transfusion was done on two of these babies, both of whom died; but the procedure was not done until the ages of 24 and 36 hours, respectively. Thus, if one is allowed to "correct" the figures and eliminate these two because of the lateness of the treatment, the result would be no cases of kernicterus in 20 babies receiving exchange transfusions.

The incidence of kernicterus has been said to be greater in premature than in full-term babies,[8] but it was not true in this small sample. There were nine infants below 5 pounds, 8 ounces; only one of these, or 11 per cent, developed kernicterus, whereas 15 per cent of the full-term babies developed it. There did seem to be a higher mortality rate in the prematures; seven of them died, and only two survived.

The use of female blood in exchange transfusions was advocated by Diamond[9] since his survival rate was so much better using this type of blood. In recent series there has not been as much enthusiasm on this point, however. In our series there were only four babies who received blood from male donors, with a 50 per cent mortality; and fifteen babies received blood from female donors,

with a 26 per cent mortality. The series is much too small to come to any definite conclusion, however.

The Use of Rh Positive Blood

It is now generally accepted that a baby with erythroblastosis should be transfused with Rh negative blood since this type is not affected by the Rh antibodies in the baby's circulation. It was not many years ago, however, that Rh positive blood was used in order to neutralize the antibodies present in the baby. This procedure was abandoned because it was found that in the process of neutralizing the antibodies, red blood cells were destroyed, thereby increasing the bilirubin and the jaundice.

Rh positive blood was used in two cases in 1947. One had five transfusions from his father, recovered without any ill effects, and is now in good health. The other baby had a total of 240 cc. of Rh positive blood in three transfusions, the first of which was given when he was nine hours of age; he died of kernicterus on the second day of life.

Other Antigens

Most of the cases in this series were due to immunization to the Rh_0 or "D" factor. This is the most potent of all the Rh antigens and, therefore, is reponsible for most of the cases. There were only 2 cases in the series of 66 that were due to other antigens.

The first was a baby who was group A Rh positive and whose mother was group O Rh positive. The baby showed a mild jaundice beginning four hours after birth and also a slight anemia. The anti A titer on the mother's serum shortly before delivery was 1:8192, while the anti B titer was 1:256. The difference between the two titers in this case is enough to make one sure that the disease is due to immunization to the A antigen. The Coombs' test on the baby was negative, and the baby did well without any treatment.

The other case was a baby who died very soon after birth; the diagnosis was made by postmortem examination. The mother was group A Rh positive, which would rule out the D antigen as the cause of the disease. Since titers were not done, the exact antigen responsible is not known.

Deaths

In the series of 66 cases there were 16 deaths, giving a mortality rate of 24.2 per cent. This figure does not include three babies that were stillborn and two that were dead on arrival at the hospital. However, it does include three babies that lived for less than 30 minutes and for whom no treatment could be started. If these latter three are omitted, the mortality rate is lowered to 19.7 per cent. As can be seen from the chart, many of the cases were complicated by prematurity or kernicterus.

Severity

One of the most difficult problems in the management of babies with erythroblastosis is evaluating the severity of the disease when the baby is born.[10] This evaluation is especially important since the babies often seem to be perfectly healthy in the first few hours after birth and one might be tempted to adopt a policy of watchful expectancy, which can prove tragic. Actually, two indicators of how severe the disease will be are present before the birth of the baby—the mother's obstetrical history and her level of antibodies. In this series, the mothers who had had previously affected babies had a 37 per cent mortality in their children (compared with the general 24.2 per cent mortality); and those that had lost previous babies from the disease had a 50 per cent mortality. The antibody titer also had a relation to the outcome. The average titer in mothers of fatal cases was 1:100, compared to an average titer of 1:14 in the mothers of the survivors.

After delivery of the baby one can obtain an indication of severity from physical examination and from the blood count. Those babies that are hydropic have a very poor prognosis. In this series edema was noted in five babies, and only one of these survived. Hemorrhagic tendencies also indicate a poor prognosis; but this series is not large enough to draw any conclusions as there were only two babies showing any bleeding, one living and the other dying. There was no definite indication that the babies with larger spleens or livers did poorly, although this did seem to be a general trend.

The blood counts were indicative of severity in this series. The average nucleated red blood cell count for the group of babies admitted on the first day of life was 18 nucleated red blood cells per 100 white blood cells for the survivors and 551 nucleated red blood cells per 100 white blood cells for the fatal cases. This is a significant difference. However, there was one fatal case with only

DEATHS

Year	Age on Admission	Mother's History	Antihodies	Weight	Remarks	Reason
1951	0	3 preg.—2 children stillborn	alb., 1:32 Coombs' 1:256	?	Macerated fetus	Stillborn
1950	0	5 preg.—last 2 children stillborn	1:256	?	Macerated and edematous	Stillhorn
1948	0	7 preg.—3 children	1:16	?	Macerated fetus	Stillborn
1950	5 hrs.	2 preg.—previous child stillborn	?	?	Lived 5 hrs.	Dead on arrival at hospital
1946	5 days	2 preg.—no previous trouble	1:4096	5–3	Severe immunization Premature	Dead on arrival at hospital
1951	0	4 preg.—all children died	1:1024	?Length, 15 in.	Mother transfused—treated with haptene	Premature Hydropic—lived 30 min.
1948	0	8 preg.—lost 3 children	?	3½ lbs.	Lived only few minutes	Premature
1946	0	2 preg.	?	?	Breathed only twice	
1951	0	6 preg.—no children Mother transfused	1:32	2–3	Lived 1½ hrs.	Premature
1951	0	6 preg.—5 children died jaundiced	1:8192	7–9	Exchange, 3 times—died at age of 38 hrs.	No postmortem exam Severe immunization
1950	0	?	?	7–11½	Exchange started—died in 45 min.	Hydropic
1950	0	5 preg.—2 living children	1:128	7–4	Exchange started—died in 45 min.	Truncus arteriosus
1948	0	6 preg.—1 miscarriage	?	1–10	Died on 4th day	Premature
1947	2 days	9 preg.—lost one child with EBF	1:32	5–2	Exchange through sag. sinus	Premature
1947	36 hrs.	9 preg.—6th & 7th children died with jaundice—8th O.K.	?	6–9½	Exchange, at 36 hrs. of age—died on 3rd day	Kernicterus
1947	0	No history	1:4	5–9½	Given RH+ blood	Kernicterus
1948	1 day	4 preg.—one other child died of probable EBF	1:512	6–10	C. section because of incompatibility—died on 3rd day	Kernicterus
1951	1 day	6 preg.—others and twin of patient O.K.	1:16	4–14	Coombs' test negative	Premature—died, 4 mo., with hydrocephalus
1951	12 hrs.	3 preg.—others O.K.	1:16	7–6	Exchange, at 24 hrs. of age	Signs of kernicterus—no postmortem exam
1946	3 days	2 preg.—1st O.K.		7–10	Died on 3rd day	Bronchopneumonia ?
1945	1 day	3rd preg.—all died		7–8	Section because of bleeding	Died in 1½ days

16 nucleated red blood cells, while the remainder all had above 40 and one case had the huge number of 2,000 nucleated red blood cells for every 100 white blood cells. There was also a difference in the blood counts of these groups of babies. The survivors had an average hemoglobin of 13.7 Gm. and a red blood cell count of 3,850,000, while the fatal cases averaged 9.6 Gm. of hemoglobin and 2,250,000 red blood cells. Again, there seems to be a definite difference, with the fatal cases having the lower counts.

Bilirubin values were not obtained on enough of the cases to draw any conclusions. However, a recent article by Hsia *et al.*[11] points out that any bilirubin value above 3 mg. per cent in cord blood probably means erythroblastosis, and values above 6 mg. per cent almost always do. This is not always a practical test since many hospitals do not have the facilities to do a rapid determination.

Discussion

The management of a case of erythroblastosis really starts at the time of the mother's first prenatal visit. An Rh determination should be obtained then; and if she is negative, further investigation is often in order. However, if it is her first pregnancy and she has never had a blood transfusion, one can safely tell her not to worry since it is very rare to have the first baby affected. If she has been transfused in the past or if she has been pregnant before, antibody titers should be obtained on her at the time of the first visit to determine "carry-over" antibodies (ones that she still has as a result of a previous sensitization). If she has no antibodies, it is safe to wait until near the end of the pregnancy before obtaining another determination. If she still has no antibodies, the chances are excellent that the baby will be unaffected. If she has antibodies present at

the first determination, then they should be followed at regular one- to two-month intervals to note the rise or fall.

One has an idea from the maternal history and level of antibodies whether the baby may have trouble or not. Laboratory procedures may be begun immediately after the birth of the baby and treatment instituted if necessary within one to two hours. It is felt that this plan is far superior to waiting until the baby becomes jaundiced and then doing the tests to determine the cause.

The following points relative to erythroblastosis should be borne in mind:

1. The possibility of the disease occurring should be predicted before delivery by appropriate laboratory methods.
2. A Coombs' test should be performed at birth to indicate whether the baby has the disease or not.
3. Other laboratory measures should be done to evaluate severity.
4. Exchange transfusion, if this is decided upon, should be executed within the first few hours after the birth and before the baby appears ill.
5. Kernicterus may be prevented by early treatment.

1 South Pinckney Street.

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FILM ON CLEFT PALATE CHILD AVAILABLE

A new movie, "The Wisconsin Cleft Palate Story," in sound and color, has been produced by the Bureau for Handicapped Children, Department of Public Instruction, in cooperation with the University of Wisconsin Medical School, Department of Speech, and University Hospitals. It shows the integration of services necessary in the habilitation of a cleft palate child. This 36-minute film tells the story effectively and honestly.

The film can be rented from the Bureau of Visual Instruction, University of Wisconsin, 1323 West Johnson Street, Madison, Wisconsin, for a nominal fee. It is available for purchase through the Photographic Laboratory, 1204 West Johnson Street, University of Wisconsin Extension Division, Madison, Wisconsin.

The Wisconsin State Board of Health Mobile Unit X-ray Surveys (1949-1951)

A Report of 494,442 70 mm. X-rays, 19,579 Referrals

By MILTON FEIG, M. D., and AGNES JENSEN, R. N.
Madison

THIS is a report of 494,442 70 mm. x-rays taken during the three calendar years, 1949 through 1951 inclusive, by the Wisconsin State Board of Health and a study of the six-month follow-up results. It should be of particular value to the physicians of Wisconsin who participate in the organization of their community surveys and in the study of those patients referred back to them for diagnostic purposes. It should be of interest as well to all professional groups concerned with tuberculous and neoplastic diseases of the chest.

General Survey Procedure

These surveys are conducted through the assignment of the State Board of Health's three mobile units to its district offices. In turn, the units are then placed at the disposal of the county and local public health nursing services and health departments. They then organize the survey programs as community projects in which both lay and professional groups participate. In general, local health services follow recommended policies of the State Board of Health in respect to persons or groups to be encouraged or discouraged from being x-rayed. Because of the extremely low incidence of tuberculosis in age groups under 15, children below this age should not be surveyed except under specific significant circumstances (*e.g.*, exposure to a discovered case in a school teacher, etc.). Surveys are aimed at the general population, but because of the present high prevalence in the age group over 45, particularly in the male, efforts are made to secure the participation of industrial groups, homes and institutions for the aged, mental institutions, etc.

Should the 70 mm. film be found normal, then the individual is notified to that effect by card. When significant findings are noted on the screening films, a report containing the findings is sent to the physician designated by the patient and a second report to the official health service of the patient's residence. The patient is also notified that an abnormality (no specific finding is mentioned) is suspected and advised that his physician has been informed accordingly. It is recommended that he visit his physician for diagnostic purposes.

Successful follow-up of referred cases depends on three groups of individuals:

1. The patients themselves, who for self-interest should desire and seek the recommended study.
2. Members of the local nursing or health services, who visit the referred individuals in order to encourage and persuade them to visit their physicians (these local health services are not employed by the State Board of Health).
3. The family physicians, who upon receipt of abnormal screening findings, should encourage patients to consult them to have the necessary diagnostic studies conducted.

After a six-month period, reports of follow-up results are forwarded to the State Board of Health by the responsible health agency.

The 70 mm. Screening Findings

The 70 mm. screening diagnoses are made in several categories. Only those pertinent to this report will be discussed here. Abnormal cardiac referrals are not included, not because of lack of interest but because of inadequate follow-up information. Since the original intent of 70 mm. surveys is to screen for tuberculosis, primary consideration will be given to referrals for this disease. Such referrals are reported to the physician chiefly as:

TABLE 1—*Reported Success of Six-Month Follow-up Period after Mobile Surveys for Possible Tuberculosis, Wisconsin, 1949–1951*

494,442 Persons X-rayed—19,579 Referrals

Mobile Unit Finding	Persons Referred for Follow-up[1]		Persons Examined after Referral		Not Examined after Referral	
	Number	Per Cent of All X-rays	Number	Per Cent of Group	Number	Per Cent of Group
Suspicious Tuberculosis	9,141	1.9	6,685	73.1	2,456	26.9
Apparent Tuberculosis	2,629	.5	1,923	73.1	706	26.9
Pathology of Undetermined Etiology	7,809	1.6	4,807	61.6	3,002	38.4
Total	19,579	4.0	13,415	68.5	6,164	31.5

[1] Does not include referrals for cardiac pathology or other nontuberculous and nonmalignant pathology.

TABLE 2—*Distribution of Negative and Significant Findings Among 13,415 Persons Examined in Follow-up for Possible Tuberculosis, Wisconsin, 1949–1951 Inclusive*

Mobile Unit Finding	Persons Examined after Referral	Follow-up Findings			
		Negative		Significant	
		Number	Per Cent	Number	Per Cent
Suspicious Tuberculosis	6,685	4,566	68.3	2,119	31.7
Apparent Tuberculosis	1,923	579	30.1	1,344	69.9
Pathology of Undetermined Etiology	4,807	2,746	57.1	2,061	42.9
Total	13,415	7,891	58.8	5,524	41.2

1. Suspicious tuberculosis
2. Apparent tuberculosis
   (a) minimal
   (b) moderately advanced
   (c) far advanced
3. Pathology of undetermined etiology

These three categories are considered in the tables under the heading, "Mobile Unit Finding."

19,579 persons were referred to their family physicians for diagnostic follow-up (Table 1). They constitute 4.0 per cent of the 494,442 persons x-rayed. Of the 19,579 referrals, 9,141 (46.7 per cent) were for suspicious tuberculosis; 2,629 (13.4 per cent) for apparent tuberculosis; and 7,809 (or 39.9 per cent) for pathology of undetermined etiology.

Examination of Referred Cases (Table 1)

During the six-month follow-up period, 13,415 persons (68.5 per cent of those referred) were examined by their doctors. There were 2,456 referrals in the "suspicious" group and 706 in the "apparent" tuberculosis group who were not examined even once during this interval. This is about 27 per cent of each of these two groups. About 3,000 persons of those referred for pathology of undetermined etiology, constituting almost 40 per cent of that group, were not examined. A total of 6,164 persons recommended for follow-up during the three-year period did not receive the benefit of any type of medical examination. Referrals in which the stethoscope was the only diagnostic instrument used by the physician were placed in the "examined" group. The possible reasons for the failure to receive an examination are varied and many.

Findings in Examined Referrals

The findings in referred cases after examination are listed as:

1. Negative (including healed primary lesions)
2. Definite tuberculosis in various classifications
3. Heart disease
4. Cancer
5. Pathology of undetermined etiology
6. Other abnormalities

Each will be discussed under the proper referral category.

Negative Findings (Table 2)—7,891 referrals, almost 60 per cent of those examined,

TABLE 3—*General Distribution of Significant Follow-up Findings Among 5,524 Persons of 13,415 Referred for Examination for Possible Tuberculosis, Wisconsin, 1949–1951 Inclusive*

Mobile Unit Finding	Follow-up Finding				Total
	Definite Tuberculosis		Other Definite and Undetermined Pathology		
	Number	Per Cent of Each Examined Group	Number	Per Cent of Each Examined Group	
Suspicious Tuberculosis	1,310	19.6	809	12.1	2,119
Apparent Tuberculosis	1,116	58.0	228	11.9	1,344
Pathology of Undetermined Etiology	489	10.2	1,572	32.7	2,061
Total	2,915	21.7	2,609	19.4	5,524

TABLE 4—*Activity Status of 2,915 Tuberculosis Cases as Determined after Six-Month Follow-up of Survey Referrals for Tuberculosis, Wisconsin, 1949–1951 Inclusive*

Mobile Unit Finding	Persons Examined	Reported Follow-up Finding of Tuberculosis									
		Active		Inactive		Suspected Active		Undetermined Activity		Total	
		No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent
Suspicious Tuberculosis	6,685	87	1.3	782	11.7	166	2.5	275	4.1	1,310	19.6
Apparent Tuberculosis	1,923	184	9.6	642	33.4	87	4.5	203	10.5	1,116	58.0
Pathology of Undetermined Etiology	4,807	30	0.6	293	6.1	78	1.6	88	1.9	489	10.2
Total	13,415	301	2.2	1,717	12.8	331	2.5	566	4.2	2,915	21.7

were considered negative after subsequent examination; *over 40 per cent had evidence of definite pathology.* A great variation, however, is noted in each referral group. Of those referred as "suspicious" tuberculosis, 68 per cent were reported negative, as were 57 per cent of those referred for "pathology of undetermined etiology." Only 30 per cent of those referred through screening surveys as "apparent" tuberculosis were negative. When it is considered that the 70 mm. x-ray is a screening and not a diagnostic device, and that over 40 per cent of the referred cases were subsequently found to have significant pathology, the effectiveness and value of such screening becomes apparent.

Tuberculosis Findings—After referral to and examination by their family physicians, 2,915 patients were found to have tuberculosis. They made up over 20 per cent of the total number of patients examined after referral (Table 3). They were reported back to the State Board of Health with all degrees of activity status (Table 4):

1. Active—301 cases
2. Inactive—1,717 cases
3. Suspected activity—331 cases
4. Undetermined activity—566 cases

Such numbers represent a tuberculosis case-finding rate (based on 494,442 persons surveyed) of 5.9 per thousand and an active tuberculosis rate (including presumably or suspected active cases) of 1.3 per thousand persons x-rayed.

When rates are determined on the basis of those examined after referral, then the general tuberculosis rate is 217 per thousand persons referred, with an active (and presumably active) rate of 47 per thousand referrals.

No stronger data need be presented to show the effectiveness of the mobile 70 mm. x-ray unit as a screening mechanism for tuberculosis alone and to prove that despite the decline in death rates from this disease, it still presents a public health problem of the first magnitude.

Cancer Findings—During the three-year period, 93 cases of cancer were found in the 13,415 patients referred and subsequently examined (Table 5). A sampling study of 35 of these cases showed that 18 of them had died from cancer within one year from the date of referral.

The value of the mobile unit survey as a mechanism for the detection of chest cancer

TABLE 5—*Distribution of Cancer, Heart Disease, and Other Significant Follow-up Findings among 13,415 Persons Examined for Tuberculosis, Wisconsin, 1949–1951 Inclusive*

Mobile Unit Finding	Persons Examined	Report Follow-up Finding of:							
		Cancer		Heart Disease		Other Pathology		Undetermined Etiology	
		No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*
Suspicious Tuberculosis	6,685	12	1.8	200	30.0	324	48.5	273	40.8
Apparent Tuberculosis	1,923	7	3.6	50	26.0	97	50.4	74	38.5
Pathology of Undetermined Etiology	4,807	74	15.4	480	99.9	610	126.9	408	84.9
Total	13,415	93	6.9[1]	730	54.4[2]	1,031	76.9[3]	755	56.3[4]

*Rate expressed as per 1,000 persons examined.
[1]Rate for 494,442 persons surveyed is 0.19, or 2 per 10,000.
[2]No general survey rate is given since these cardiac findings do not include those referred specifically for heart disease.
[3]Rate for 494,442 persons surveyed is 2.1, or 21 per 10,000.
[4]No general survey rate is given because diagnosis is incomplete.

may be expressed, on the basis of total persons x-rayed, as a rate of 2 cases per 10,000 and, on the basis of persons referred and examined for follow-up, as 7 per thousand or *35 times as great as in the general population surveyed.*

Heart Disease and Other Findings—It is interesting to note (Table 5) that 730 cases of heart disease were diagnosed in persons examined primarily for pulmonary pathology. This figure is 5.4 per cent of the total number of persons examined. It does not include a vast number of persons (11,041) referred primarily for cardiac disease as detected in the initial screening during this three-year period. What proportion of those in either group had previous knowledge of heart disease is not known. The State Board of Health is at present engaged in a long-range study to determine the value of the 70 mm. x-ray as a screening mechanism to detect new cases of heart disease and bring such persons under medical care.

Over 1,000 persons (7.7 per cent of all referrals) were found to have pulmonary pathology other than tuberculosis or cancer (Table 5), and in 5.6 per cent more (755 persons) the etiology of the pulmonary pathology had not yet been established at the date of the six-month follow-up report.

Follow-up Findings as Related to Referral Findings

It should be of great value to the family physician to know what the experiences of other physicians in the state have been with each of the referral categories. Follow-up findings will be indicative of what results he might expect in his examination of the referred patients in each category. The information should be of aid to him as a guide in diagnostic evaluation.

Suspicious Tuberculosis—About 70 per cent of the patients referred with this screening diagnosis will, according to this study, be found negative (Table 2); and about 30 per cent will show significant findings.

About one of every five patients referred will have tuberculosis (Tables 2 and 3), and almost 60 per cent of these cases will be considered inactive (Table 4). These persons with inactive disease should be checked periodically in order to detect reactivation at the earliest possible moment.

One out of twenty-five patients in this referral group will have active or presumably active tuberculosis; and in a similar number of patients a diagnosis of tuberculosis will be made but the investigation for determination of activity status will be interrupted before completion.

Lung cancer will be found in .2 per cent of this group, and heart disease will be found in 3 per cent. An additional 9 per cent of the group will be found to have significant chest pathology of some other type (Table 5).

In general, this referral group contributes two out of every five active or suspected active cases of tuberculosis found (253 of 632), three-tenths of the heart cases (200 of 730), and one-eighth of the cancer cases (12 of 93).

Apparent Tuberculosis—As may be expected, the screening findings in this group received the strongest diagnostic verification. Only 30 per cent of these patients were found

to be negative (Table 2), and almost 60 per cent were found to have tuberculosis (Table 3).

Of those found to have tuberculosis, one of every four was considered an active or presumably active case (271 of 1,116).

Although seven cases of cancer of the lung were reported in this group as compared with twelve in the previous group, it must be realized that only 1,923 persons were examined as compared with 6,685 in the first group. The cancer detection rate is 3.6 per thousand, about *two times higher* than in those referred for "suspicious" tuberculosis and *20 times higher than the general survey rate.*

About 2.5 per cent of referrals for apparent tuberculosis will be found to have heart disease, and an additional 9 per cent will have other significant chest pathology.

While this group is responsible for only one-seventh of the referrals for tuberculosis, it yields 43 per cent of all the active or presumably active cases found on survey (271 of 632). Despite the fact that this group has the smallest number of cancer cases (7), the cancer detection rate is higher than in the preceding group of referrals.

Pathology of Undetermined Etiology—Forty per cent of all mobile unit referrals are made under this screening diagnosis. For some reason, probably because of the tuberculosis yield, there has been a tendency among physicians and public health workers to feel that persons referred in this category need not be followed (40 per cent not examined—Table 1). Is this attitude justifiable?

Upon examination, 43 per cent of this group will be found to have significant pathology. The total tuberculosis yield is 10 per cent, as compared with 20 and 60 per cent in the other two categories; but about one-fourth of the cases in this 10 per cent will be considered to be active or presumably active.

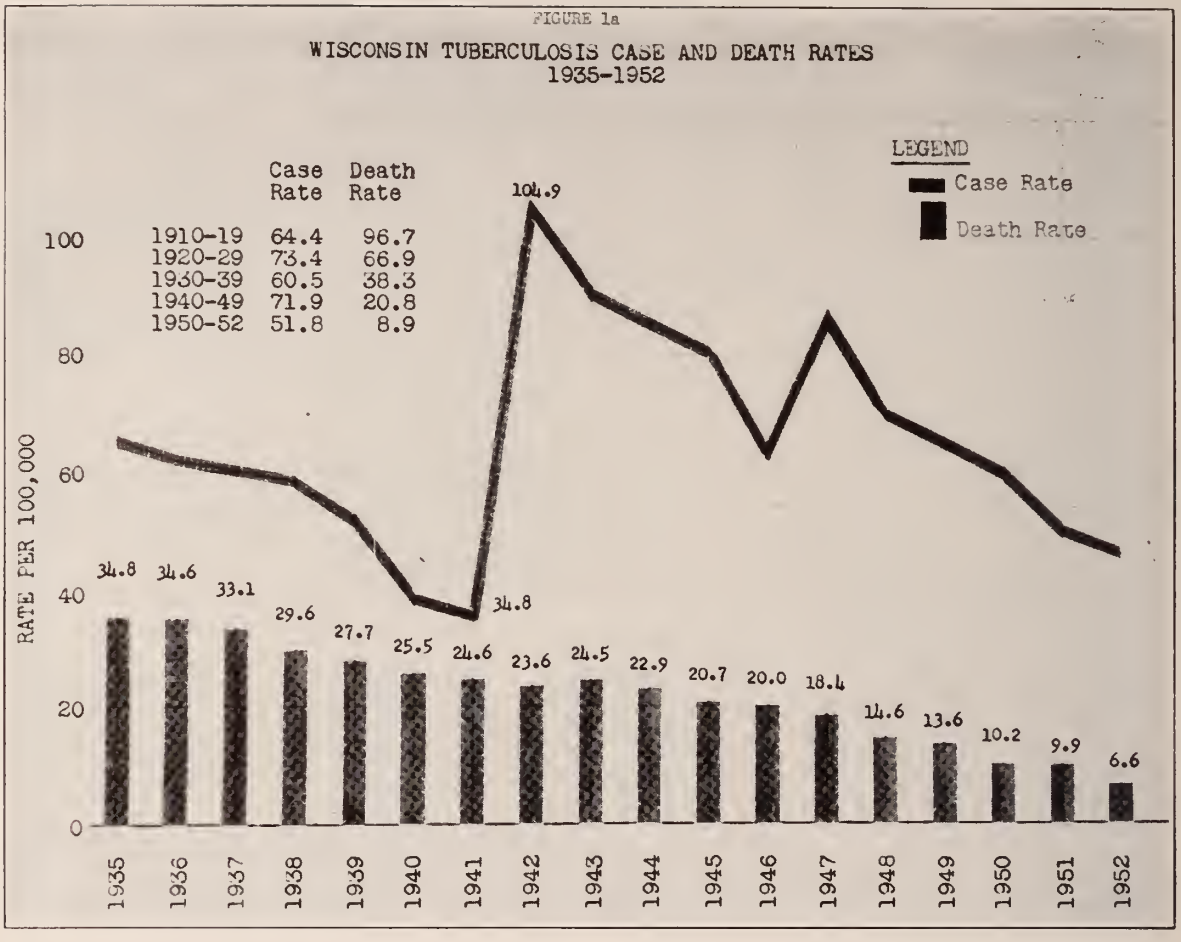
The cancer and heart disease discovery rates in this referral group are extremely high. *One and one-half per cent of those in the group will be found to have cancer (15 persons per thousand, 79 times the general survey rate). Ten per cent will have heart disease.* Twenty-one per cent will have additional significant pathology. Although less tuberculosis will be found in the group referred for pathology of undetermined etiology than in the preceding two groups, *more than three-fourths of all the cancers found as a result of referral (74 of 93) will come from this group.* It certainly is not a group in which follow-up may be delayed or neglected.

Discussion and Summary

The material presented in this paper is a portion of the data studied by the State Board of Health in the process of evaluating and improving its mobile unit surveys as a screening device for the detection of tuberculosis and other diseases. For the purposes of this presentation, age-sex breakdowns in respect to the populations participating in the surveys in various types of survey centers, as well as their correlation with both screening and follow-up findings, have been omitted. In general, such information agrees with that from previous studies, which show that pulmonary tuberculosis and cancer are much more common in age groups over 45 than in the lower age groups and that, in the older age groups, the diseases occur predominantly in the male sex. Heart disease is also much more frequent in this older age group than in lower age groups.

Tuberculosis—While many factors will influence the success of small-film screening as a tuberculosis case-finding mechanism, the most obvious and important factor is the actual prevalence and incidence of the disease in the groups screened. If tuberculosis is two or three times more common in one group of 100,000 persons than in a second group, then two to three times more tuberculosis will be found on screening the first group as compared with screening the second. Thus, the value of the 70 mm. x-ray survey as a case-finding mechanism must decrease with a decreasing incidence and prevalence.

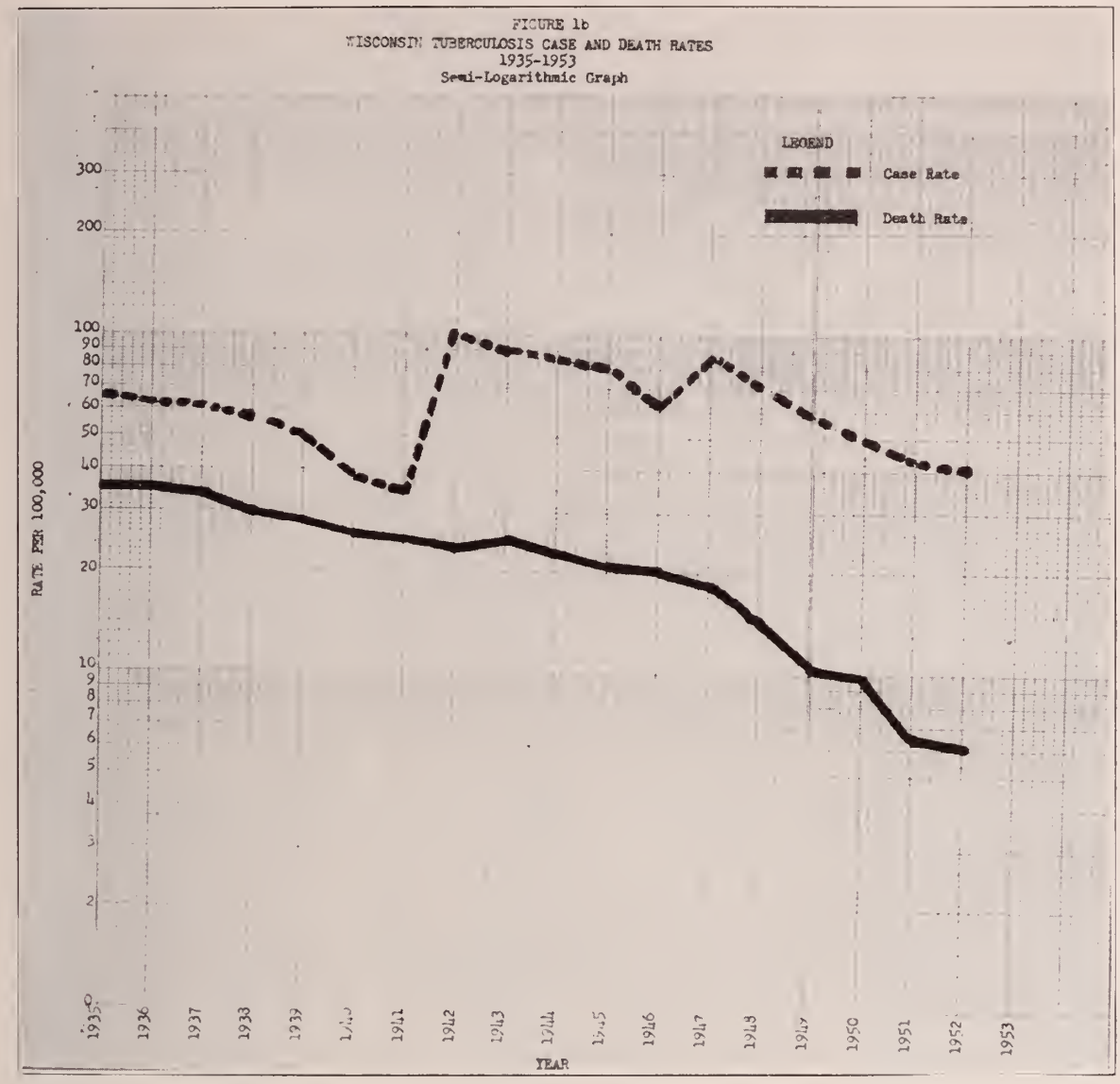
Since the beginning of the century the decrease in death rates from tuberculosis has been progressive and astounding. In Wisconsin, death rates have declined from an average of 96.7 per hundred thousand in the period from 1910 to 1919 to 6.6 in 1952 (Fig. 1a). This is a drop of 93 per cent. Does this reflect a proportionate decrease in the extent of the tuberculosis problem in Wisconsin? Any public health disease problem is measured by the number of people diseased; the communicability of the disease; and the nature of the disease as measured by its mortality rate, the severity and dura-



tion of illness, the severity and duration of disability, and the tendency towards relapse or recurrence. Therefore, it becomes necessary to determine, if possible, the number of people with tuberculous disease so that we may compare mortality and morbidity trends.

A glance at Figure 1a will make it apparent that death rates alone are not an index of disease incidence, nor is the ratio of cases to deaths. Death rates can be influenced markedly by socio-economic factors, hospitalization facilities, and improvements in therapy. Case rates (based on reported cases) are readily affected by changes in classification and interpretation and, very definitely, by the extent of case-finding activity. It is dangerous even to generalize on the basis of five-year trends.

Returning to Figure 1a, we notice three crests and three troughs in the solid line representing case rates in Wisconsin from 1935 to 1952. From 1935 through 1941 the case rate fell much more rapidly than the death rate, represented by bars in the graph. Looking at this trend in 1941, one would have been justified in stating that the prevalence of tuberculosis in Wisconsin had dropped tremendously and the problem would soon no longer be with us. However, in 1942 the case rate jumped to about three times what it was in 1941—to about 105. No one can be naïve enough to believe that this increase was due to a sudden epidemic and that the vast majority of these cases had not also existed in previous years. Actually, the tremendous increase in reported cases at this time was due to the vast selective service medical examination program as a result of our entry into World War II and the inauguration of the first State Board of Health mobile x-ray unit and another by a voluntary agency. The curve of reported incidence dropped markedly from the 1942 high to another low in 1946. Again, a prediction of the tuberculosis trend in Wisconsin based on a five-year curve would have been fallacious since a second peak, due to



increased case finding with the addition of two more mobile units to the State Board of Health and with the Korean "incident," would have soon negated any optimistic trend predictions. It must be considered uncertain to base any present trend predictions for prevalence on the descending curve of incidence since 1947. As Katz[1] has pointed out, the number of reported cases as an index of trend of incidence can only be accurate when case-finding activities remain at the same level year after year; he suggests that in examining the trend of incidence, the yield of cases among those examined is more important than the total number of cases found or reported annually. This generalization, also, is subject to many variables.

In spite of the unpredictability and difficulty in estimating the present prevalence and future trend of this disease, many official public health agencies are having difficulty in maintaining programs because of decreasing federal and state legislative appropriations for such activity. In most cases the decrease in appropriations is based on the fact that death rates are decreasing and that there have been improvements in therapy.

The great discrepancy between the decreasing case and death rates in Wisconsin is shown in Figure 1b, a semi-logarithmic graph of the data in Figure 1a. Here it is more readily seen that while the case rate has decreased but slightly, the death rate

has decreased markedly; and the difference between the two is greatest at the present time.

While there is bound to be a variation from state to state, the relative constancy of the mobile unit as a case-finding mechanism is remarkable. About one active case of tuberculosis has been discovered for every thousand persons screened. The Public Health Service, in a survey of 6,000,000 people made over a period of five years in 17 large cities and counties of the United States, finds the prevalence of active tuberculosis to be 0.7 to 0.8 per 1,000 persons.[2] The rate in the Wisconsin State Board of Health surveys is 0.6 for active cases and 1.3 for active and presumably active cases.

Based on a tremendous study, Anderson[3] states that between 2 per cent and 7 per cent of those screened will need confirmatory 14 x 17 films. Our data follows the same proportions; approximately 4 per cent of those screened are referred for follow-up for pulmonary pathology and about an additional 2 per cent for possible cardiac study. The figures in other studies[4-6] also fall within the same scope.

The State Board of Health follow-up results of those referred for pulmonary tuberculosis also conform to those of most other surveys. Of the cases examined after screening referral, 41 per cent will have significant pulmonary pathology and over 10 per cent of the referred group will have active tuberculosis (Table 4). If to this group we add those with suspected activity, then the percentage is raised another 11 per cent, to 21 per cent. This is slightly, but not significantly, below the percentage in the Public Health Service surveys,[2] where the range was from 21.7 to 52.0 per cent; and, similarly, it is slightly below the percentage in the other surveys cited.

Cancer—Greater differences, however, are to be found in respect to cancer detection through the use of 70 mm. film screening. It is unfortunate that the previously quoted surveys cannot be used for comparison purposes since follow-up findings regarding neoplasms are not differentiated in the general grouping used, "Nontuberculous Chest Disease." However, Bondi and Leites[7] report a follow-up yield, based on almost a quarter million 70 mm. films taken in New York City during 1949 and 1950, of one case of cancer per 10,000 films; and Overholt[8] cites Hilbish's report of Public Health surveys in three large cities, which also gives the yield of primary pulmonary malignancy as one per 10,000 films. In a Boston survey study of over a half million films, Overholt[8] found 76 diagnosed cancer cases, a rate of 1.4 per 10,000; and a final report of this survey by Scamman[9] adds nine additional cases, for a rate of 1.6 per 10,000. In the Los Angeles County survey of 1950, in which about 2,000,000 small films were taken, Griss[10] reports that there were 340 cases of confirmed neoplasms, a rate of 1.7 per 10,000 films. The Wisconsin rate in the present study, based on almost a half million films, is two cases per 10,000 films.

Heart Disease—When the Wisconsin study concerning the value of the 70 mm. film as a heart disease detection mechanism is completed, it will be published. It must be pointed out that over 5 per cent of those referred primarily for pulmonary pathology are found to have heart disease (Table 5).

Improving Survey Effectiveness—Although the State Board of Health case-finding x-ray surveys compare favorably with those throughout the country, there is little justification for complacency.

We cannot help but note that almost one-third (31.5 per cent, or 6,164) of the persons referred for follow-up did not have the recommended examinations (Table 1). This is a poor showing compared with showings in other surveys. In the Public Health Service surveys, involving 6,000,000 persons, the response was between 80 to 95 per cent; in the Iowa survey, the response to referral recommendations was 85 per cent, and it was about 84 per cent in the Delaware survey.

Nor can we be satisfied with the fact that after a minimum of six months, the diagnosis by physicians in 755 persons should remain so vague as to be reported back to us as "pathology of undetermined etiology" (Table 5); that after this interval of follow-up the best that can be determined in respect to the activity status of 566 tuberculous persons is that it is as yet undetermined; and that in another 331 persons, the status is reported as suspected tuberculosis (Table 4).

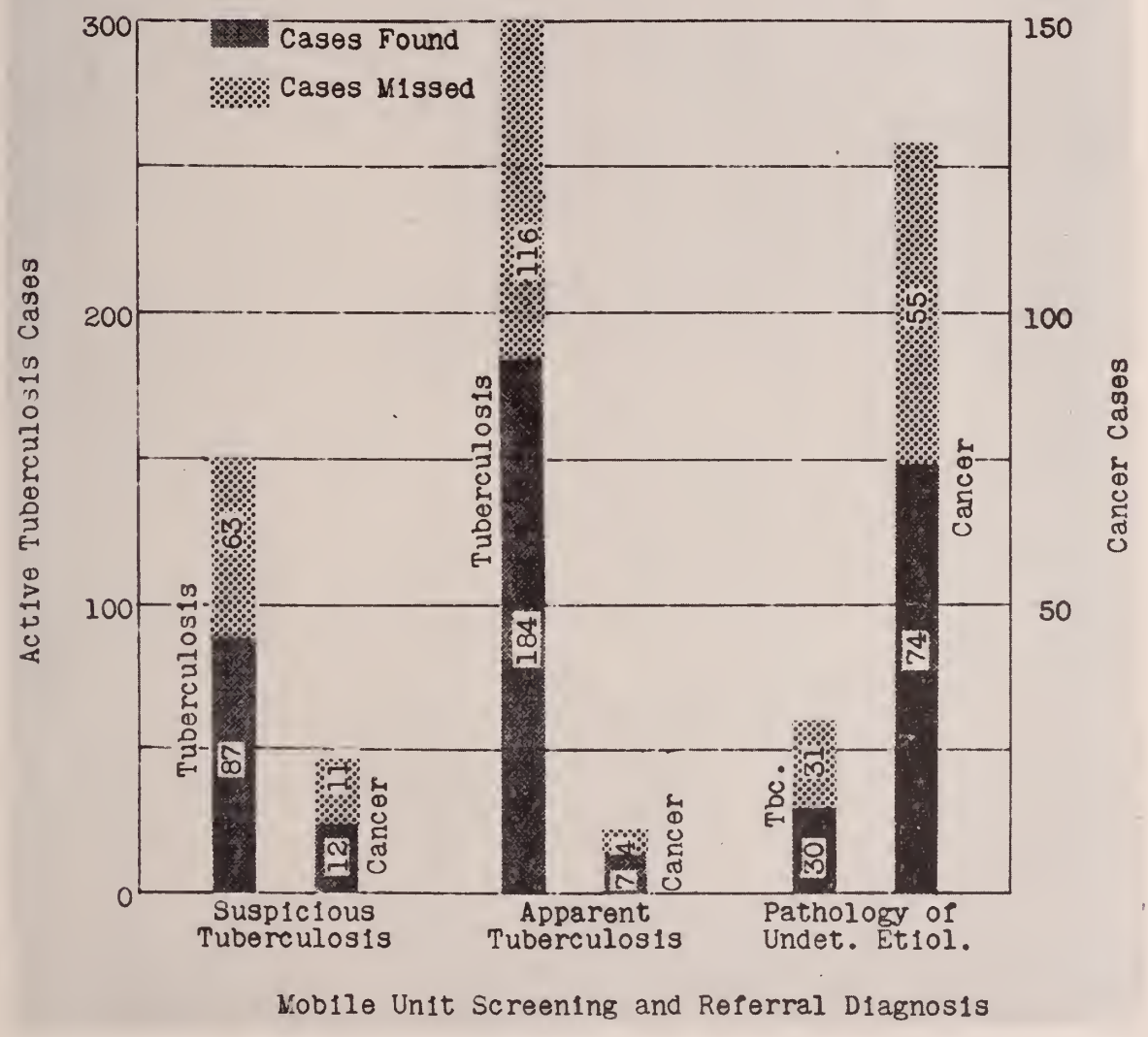
Figure 2 shows very graphically the number of active tuberculosis cases and cancer cases in each referral category missed through incomplete or no examination. These

Figure 2

Wisconsin State Board of Health Mobile Unit Survey
494,442 X-Rays, 19,579 Referrals for Additional Examination
(1949-1951 Inclusive)

Cases of Active Tuberculosis and Cancer Found
Through Complete Examination of Referrals

Cases of Active Tuberculosis and Cancer Missed
Through Incomplete or No Examination of Referrals



missed cases have been calculated on the basis of results in those already examined in each referral category. An estimated 210 active cases of tuberculosis, most of them in the referral category of "apparent tuberculosis," have been "lost." Had these patients been examined, an increased case finding of about 60 per cent would have been achieved.

Seventy cases of cancer have been "missed," with the great bulk of them in the referral category of "pathology of undetermined etiology." Had all referrals been completely examined, the mobile unit cancer detection rate would almost have doubled! Surely, no public health worker and no physician can afford to neglect persons for whom follow-up is recommended in any of these three screening categories.

What can be done to increase the effectiveness of the x-ray survey program in Wisconsin? The first step is to get the suspect to the physician. The responsibility after that is that of the physician to whom the referred patient comes. Most patients readily seek the aid of their family physicians when follow-up is recommended; but quite a few need some degree of persuasive activity on the part of the local public health nurse, to whom such responsibility must be delegated. These nurses are employed on either a local or county basis. In Wisconsin, a public health nurse carries on a generalized program involving many activities. The long-recommended ratio is one public health nurse for every 5,000 people. Some of our counties do not employ a single public health nurse, and in many instances where nurses are employed the ratio is often as great as one to every 25,000 people. Most nurses are doing as well as they possibly can. What is the ratio in your county, Doctor?

All other factors being equal, the case-finding effectiveness of an x-ray survey is directly proportionate to the number of persons x-rayed. The State Board of Health operates only three of the seven mobile units in the State of Wisconsin. Two of the other four are operated by local or county governmental units and two by voluntary agency groups. Of these four units, only one takes more films annually per unit than those of the State Board of Health; the other three average four-fifths to one-fifth as many. With our present facilities, the State Board of Health takes about 150,000 films per year. It would take 15 years or more to x-ray all presently eligible persons just once! Yet at this writing there is an excellent possibility that even this inadequate service may have to be abandoned because of decreasing federal aid and the absence of sufficient state appropriations.

It is hoped that the material presented here will act as a diagnostic working guide for the physicians to whom patients are referred. In the detection of tuberculosis the order of productiveness for the screening groups, based on rates for each group, is "apparent tuberculosis," "suspicious tuberculosis," and "pathology of undetermined etiology." In cancer detection the last-named referral group is by far the most significant and, hitherto, the most neglected in follow-up.

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THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The eighteenth annual meeting of The New Orleans Graduate Medical Assembly will be held March 7 to 10. Eighteen outstanding guest speakers will participate. The Assembly has planned another interesting postclinical tour to follow the New Orleans meeting. On March 12, a party of doctors and their families will leave New York for Europe.

Details of the New Orleans meeting and the postclinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.

Clinicopathologic Conference

Sponsored by the Section on Pathology, State of Wisconsin Medical Society
Guest Editor: Norbert Enzer, M. D.

REPORT OF A CASE*

Dr. Norbert Enzer: We have an unusual and complex problem to discuss today. The condition illustrated in the clinical course and postmortem findings of this case, lesions affecting the vascular system, is one about which there is increasing awareness.

Dr. N. F. Gordon: The clinical record in this case may be summarized as follows: The patient was a 48-year-old, white female who was admitted to the hospital with the complaints of swelling of the ankles, weakness, and tiredness for a period of approximately six weeks. At first, this swelling receded at night; later it was progressive, finally becoming constant. Accompanying this increase in the swelling of the ankles, there was a progressive dyspnea. The patient noted "red blotches" in the form of hot, raised, non-tender areas on both legs below the knees. Shortly before admission she noted swelling of the hands, face, and eyes. Other changes included numbness of the feet, a tendency for the fingers to become white when cold, and a weight gain of 8 to 9 pounds.

The past history indicated that there had been swelling, tenderness, and increased heat of multiple joints nine years prior to admission. There was also a history of allergy to tomatoes. The family history was not helpful. The patient had had numerous surgical operations, including an appendectomy and a supercervical hysterectomy with salpingectomy and oophorectomy, as well as operations for varicose veins and hemorrhoids. Laboratory work prior to admission revealed hematuria and albuminuria. No history of therapy before admission was noted.

Physical examination on admission revealed a blood pressure ranging from 140–174/84–110, with a pulse of 88. Edema of the head, eyes, and lower extremities was present; the ankles showed a two to four plus pitting edema, and the lower legs had a brawny appearance. A questionable Homan's sign was elicited. Some examiners felt the edge of the liver as well as the spleen. The patient's hair was quite coarse.

Shortly after admission the patient began to show evidence of pulmonary edema with multiple rales and, later, evidence of pleural effusion. It was felt that she was in cardiac failure, and so she was digitalized.

Six days after admission a sore throat and bilateral petechial hemorrhages of the soft palate developed. At this time the patient complained of severe right lower quadrant abdominal pain with radiation to the back. Slight rebound tenderness of the abdomen and absent bowel sounds were noted. One week after admission there was pain in the occiput, and a spinal fluid tap released grossly bloody fluid. On the following day there was definite evidence of nuchal rigidity.

Approximately 12 days after admission the patient became quite dyspneic, and on this day Jacksonian-type seizures involving the left side of her body occurred. She rapidly became comatose and remained so throughout the remainder of her hospital course. A spinal tap was repeated, and again the fluid was bloody. The patient shortly developed a strabismus and showed various degrees of generalized edema. She died on the sixteenth day after admission.

Her temperature ranged from 99 to 102 F. during the first twelve days, then ranged from 102 to 104 F. until the final day, when it ranged from 104 to 107 F. The pulse varied from 70 to 160 and the blood pressure from 142–224/80–120. The hypertension was persistent until the patient's death. Treatment included use of supportive measures, oxygen, blood transfusions, platelet transfusions, penicillin, ACTH, digitoxin, and Cedilanid.®

The clinical laboratory work is summarized in the following chart:

* From the Department of Pathology, Mount Sinai Hospital, Milwaukee.

	Admission	Mid-Course	Terminal
Blood			
Red blood cells	2,860,000	3,700,000	4,500,000
Hemoglobin	8.5 Gm. per cent	11.5 Gm. per cent	13.5 Gm. per cent
White blood cells	3,400	18,100	37,150
Segs	67	70	10
Non-segs	4	17	10
Lymphocytes	21	11	1
P. M. E.	3	------	------
Monocytes	5	2	4
Platelets	100,000	60,000	46,150
Prothrombin	100 per cent	78 per cent	82 per cent
Bleeding time	12.5′	------	------
Coagulation time	4′ 20″	------	------
Clot retraction	Initial, 1 hour; complete, 24 hours		
Sedimentation rate	3 mm. (1 hour)	------	------
Coombs' test	Reported positive and negative		
L. E. preparations	Negative	------	------

The bone marrow showed consistent hyperplasia, involving the red blood cell series, granulocytes, and megakaryocytes; some abnormal megakaryocytes were present.

Chemistry			
Nonprotein nitrogen	47.6 mg. per cent	80.6 mg. per cent	163 mg. per cent
Creatinine	------	------	3.9 mg. per cent
Proteins	5.6 Gm. per cent (3.2/2.3)	----	---
Urine			
Specific gravity	1.009	1.015	---
Albumin	3 plus	3 plus	4 plus
Sugar	Negative	Negative	Negative
Microscopic examination	Many red blood cells, white blood cells, and granular casts seen throughout course		

In addition, the patient had normal red blood cell corpuscle saline fragility, serum chlorides, carbon dioxide combining power, and serum calcium and had a negative Bence Jones protein.

X-ray examinations revealed pulmonary congestion, edema, and bilateral pleural effusion on the third day after admission; on the seventh day after admission, there was regression of most of these findings, although a left pleural effusion was still present. A KUB film was negative. An electrocardiograph tracing revealed changes due to digitalization.

We were unable to arrive at a definitive diagnosis. A favored condition was lupus erythematosus, with an additional consideration being some obscure and ill-defined condition affecting the function of the platelets and clotting mechanism.

I would like to amplify our opinions and discuss some of the features of this case in more detail. When the patient was first seen, she presented a rash on her legs, swelling of the ankles, and albuminuria. In the order given, the diagnoses at that time were: (1) Unspecified dermatitis; (2) cardiac decompensation; and (3) renal disease. However, because of the multiplicity of symptoms involved, a collagen disease, particularly lupus erythematosus, or possibly periarteritis nodosa, must be considered.

The features suggesting lupus erythematosus included: (1) pancytopenia; (2) vascular lesions of the brain and kidney, with bleeding; (3) pulmonary edema and pleural effusion; and (4) general features such as anorexia, fever, and debility. L. E. cells were not found in the peripheral blood or bone marrow, which does not favor a diagnosis of lupus erythematosus, although the presence of these cells has not been observed in all cases and stages of the disease and they have been observed in other conditions, indicating their lack of specificity.

Since no clear-cut diagnosis of lupus erythematosus can be made from the presented laboratory and clinical features, the next consideration must be a disturbance in hemostasis. Two features noteworthy in this case were (1) thrombocytopenia, with a hyperplastic bone marrow, and (2) a disturbance in the prothrombin. The platelet defect might be attributable to thrombasthenia. The bone marrow study demonstrated that the decrease in platelets was not due to decreased megakaryocytic activity, but rather to a possible excessive destruction of the platelets.

Pursuing this line of reasoning, we gave platelet transfusions; but there was no improvement. Re-evaluation of the hemostatic factors by Dr. Armand Quick led to the determination that the labile factor of the prothrombin was abnormal. This deficiency was treated by giving transfusions of fresh blood

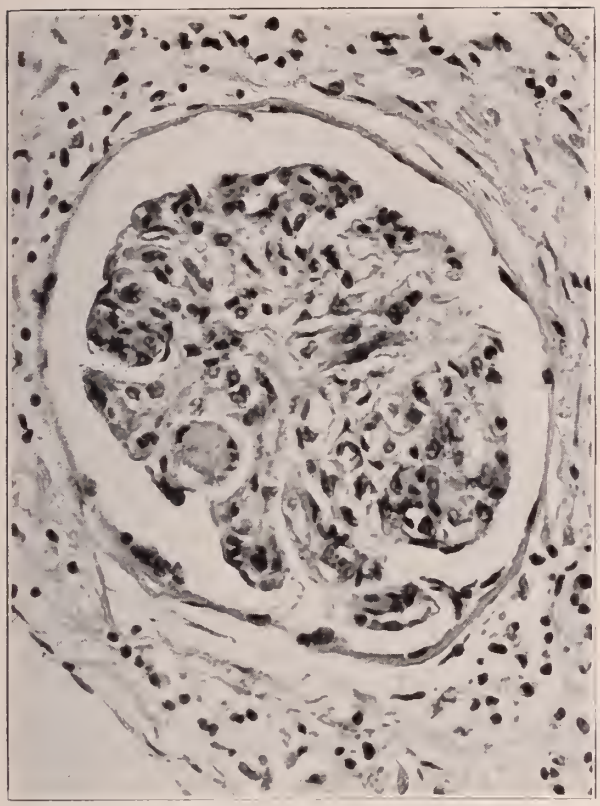

Fig. 1—Glomerulus showing bland thrombus in capillary and basement membrane thickening.

and plasma, again with no improvement in the patient's course.

A disease of recent prominence is thrombotic thrombocytopenic purpura, which is rarely diagnosed ante mortem and is, at present, uniformly fatal. While first described by Moschcowitz in 1925, it was not reported again until 1936. Then Baehr, Klemperer, and Schifrin described the entity to be characterized by purpura and anemia, with neurologic, renal, and cardiac disturbances. The anemia has been due to a hemolytic process in most instances. In this case the red blood cell fragility test to saline dilutions was normal, and the smear was negative for spherocytes. The Coombs' test was reported both positive and negative, and the serum bilirubin was normal. These findings do not completely exclude a hemolytic anemia. Reticulocyte counts, red blood cell survival time studies, and determination of fecal urobilinogen are helpful in ascertaining whether hemolytic anemia is present.

The neurologic manifestations in this case were obscured by the gross bleeding, which caused a meningitis, with marked nuchal rigidity and coma. The renal lesions were persistent; microscopic and gross hematuria, albuminuria, and granular casts were reported. The presence of cardiac lesions could be postulated on the basis of the pulmonary edema and pleural effusion which were observed, although these findings are also seen with the Libman–Sacks endocarditis of lupus erythematosus.

The therapeutic efforts in this case consisted of giving multiple transfusions of whole blood, platelets, and plasma. Intravenous ACTH, penicillin, oxygen, Mephyton, and digitalis were of no avail. Surgery was not done since the spleen was not palpable and so hypersplenism was unlikely. The exquisitely tender right lower quadrant mass was assumed to be a retroperitoneal hemorrhage rather than an intra-abdominal catastrophe.

Doctor Enzer: The postmortem examination was performed by Dr. N. E. Pond, and I will now call on him for the presentation of the findings.

Necropsy Findings

Dr. N. E. Pond: The necropsy, done shortly after death, revealed the presence of small, clear vesicles, averaging 1 mm. in diameter, scattered over the lower portion of the head, the neck, and the upper part of the chest, especially above the level of the breasts. Areas of hemorrhage into the dermis were present over the breasts and upper portion of the chest. Extensive hemorrhage was also found internally, especially in the abdominal musculature, the lungs, the cervical stump, and the retroperitoneum. The retroperitoneal hemorrhage was extremely severe; large amounts of partially clotted blood filled both of the abdominal gutters and the pelvis. The heart showed no gross changes. The viscera, including the lungs, were congested and edematous. The surfaces of the kidneys were very finely granular, although the capsule stripped with no difficulty. The cut surface of the kidney showed the glomeruli to be extremely prominent; they appeared as shiny, silver-colored, elevated, pin-point areas in the cortex, in contrast to the extremely congested background tissue. Gross vascular changes were mild. Permission for examination of the brain was refused.

On microscopic examination, striking features were found in the walls of the blood vessels. Intimal arteriosclerosis was mild;

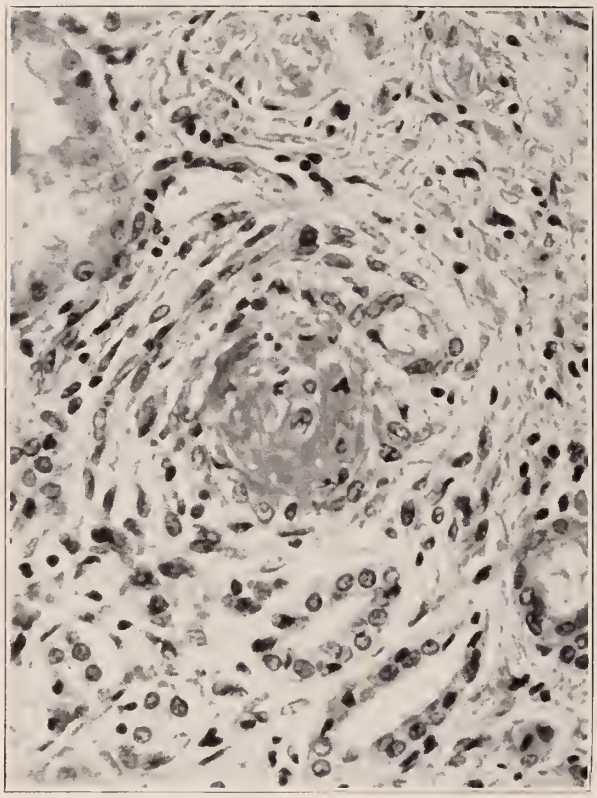

Fig. 2—Thrombosed renal vessel. Note absence of exudative inflammatory reaction.

but in the small arteries, arterioles, and, to a minor extent, the venules, changes were noted. These changes varied from acute fibrinoid intimal, subintimal, or full-thickness necrosis of the vessel walls (many vessels containing eosinophilic granular thrombi within their lumina) to eosinophilic hyaline sclerosis. In many of the sections showing the fibrinoid necrosis of the walls, the reaction was intermittent with areas of degeneration separated from one another by fairly intact vessel wall. A perivascular cuffing, with infiltration by inflammatory cells, including lymphocytes, a few neutrophils and eosinophils, and an occasional plasma cell, was seen surrounding these degenerating vessel walls. Thrombi were located in the damaged vessels, usually overlying the areas of acute necrosis, and did not fill the lumina, except in some cases in the glomerular capillaries. Usually, the thrombi were flattened and had irregular surfaces. These thrombi were granular, stained reddish brown with eosin, and usually contained no visible cellular elements.

These vascular changes were especially noted in the skin, lungs, liver, gallbladder, spleen, pancreas, kidneys, and urinary bladder. Specific examination of the skin revealed vesicles between the stratum corneum and the stratum granulosum. Many areas of the stratum basalis were irregular; and in the immediate subepidermal zone, there were areas of considerable eosinophilic change in the outer dermal collagen. In the glomeruli, evidence of proliferation of both the epithelial and endothelial cell elements was present. Granular eosinophilic thrombi were noted in some of the small capillaries of the glomerulus. Many of the glomeruli also revealed an acute inflammatory infiltrate such as that seen in terminal glomerulitis.

Older lesions included proliferative changes in Bowman's capsules, subcapsular wedge-shaped scars with chronic inflammatory cell infiltration, and older vascular lesions. There was also some thickening of the capillary basement membranes in the glomeruli, but no "wire looping" effect was seen. The cervical stump revealed extensive ramification of sclerosed arteries and veins, many showing necrotic changes in their walls.

Examination of the bone marrow revealed very severe hyperplasia of all elements, including the granulocytes, the red blood cell elements, and the megakaryocytes. Most of the megakaryocytes were morphologically normal. Hyaline bodies were present in the bone marrow, although they were very few in number. In this regard, we recall that no L. E. cells were observed in the bone marrow aspirations done prior to death. The heart presented no specific changes. Cystic acinar dilatation of the pancreas, as seen in uremia and other conditions, was present.

Doctor Enzer: The great variety and extent of the lesions has been illustrated by lantern slide demonstration. We make no pretense of being able to tie this case up into a neat diagnostic bundle. The immediate cause of death may reasonably be retroperitoneal and intracranial hemorrhage. The massive retroperitoneal hemorrhage was due to or had its origin in extensive angiomatosis surrounding the stump of the cervix. In this area, arteritis with thrombosis, and enormous distention of veins with hemorrhage was apparent. This angiomatosis is not related to the basic disease under consideration except that the vessels in this area were involved in the same manner as vessels in other parts of the body. We cannot

positively account for the intracranial hemorrhage; but in the light of other findings, it would appear reasonable to interpret it as the result of the vasculitis which was demonstrated in so many areas.

The outstanding feature in this case, of course was the widespread involvement of arterioles. The changes ranged from arteritis and periarteritis to necrotizing arteritis and thrombosis of medium and small arteries and precapillary vessels. The thrombi were mostly bland and were almost always associated with vascular damage, acute and chronic, ranging from scant intimal and subintimal lesions to necrosis with or without inflammation of the vessel wall. It is notable that the inflammatory exudate involving the arteries was nowhere characterized by eosinophilia.

We also have to consider the possibility that we may have had a contributing condition in the form of a lupus erythematosus. Changes in the skin were not typical for lupus, yet they might have represented the healed or atrophic phase of the condition. The bone marrow studies during the lifetime of the patient did not disclose any L. E. cells, but the examination of sections of the bone marrow after death did disclose hematoxylin-like bodies; while not absolutely characteristic for lupus erythematosus, these findings nevertheless were similar to those in lupus erythematosus. Some changes noted in the kidney also fit into this same category.

We have some clinical as well as postmortem evidence which would support a diagnosis of thrombotic thrombocytopenic purpura. A review of the literature which first discussed this condition in 1925 (in a report by Moschcowitz), discloses that postmortem examinations in cases of this disease exhibit a wide range of tissue damage. In this case some of the features of thrombotic thrombocytopenic purpura were lacking, but many other features were present.

Our interpretation of this case is that we were dealing primarily with vascular damage and that the thrombosis was a secondary condition not actually related to a primary disorder of the thrombocytes. In that respect it might be well to classify this as a case of vasculitis; but there were conflicting findings, so we are inclined to classify the case as having evidences of thrombotic thrombocytopenic purpura, vasculitis, and glomerular nephritis of the proliferative

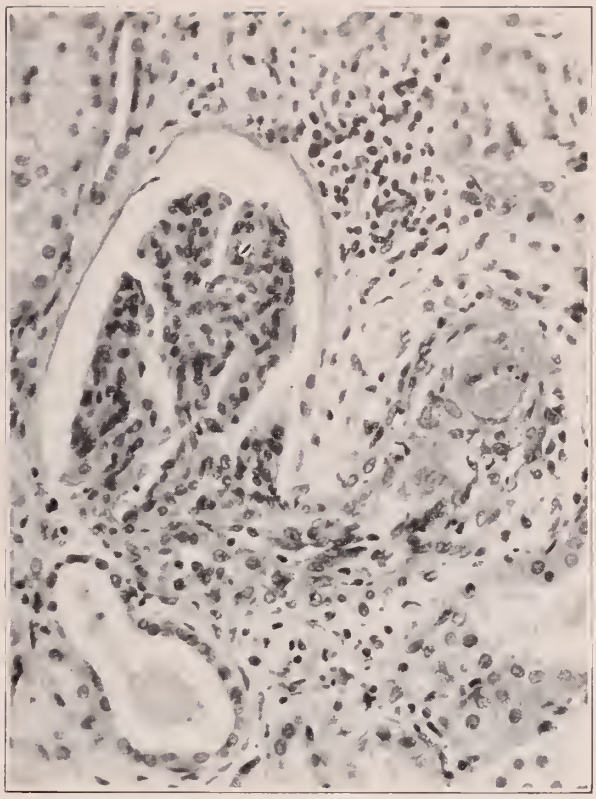

Fig. 3—Afferent vessel thrombosis in kidney.

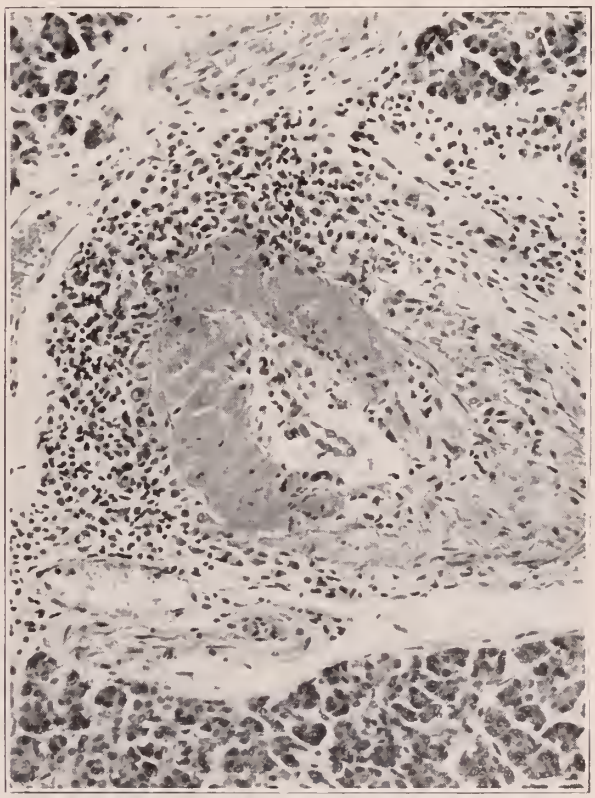

Fig. 4—Necrotizing arteritis and periarteritis of pancreas.

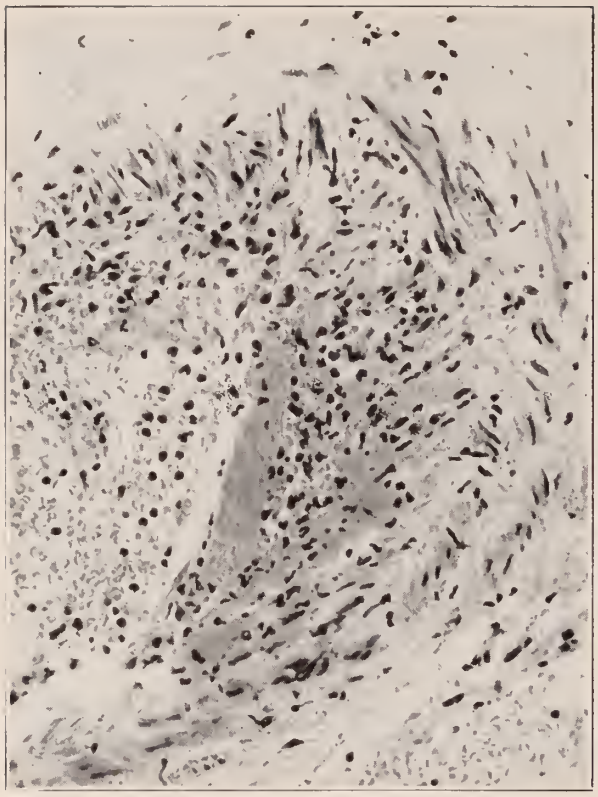

Fig. 5—Necrotizing arteritis and periarteritis in skin

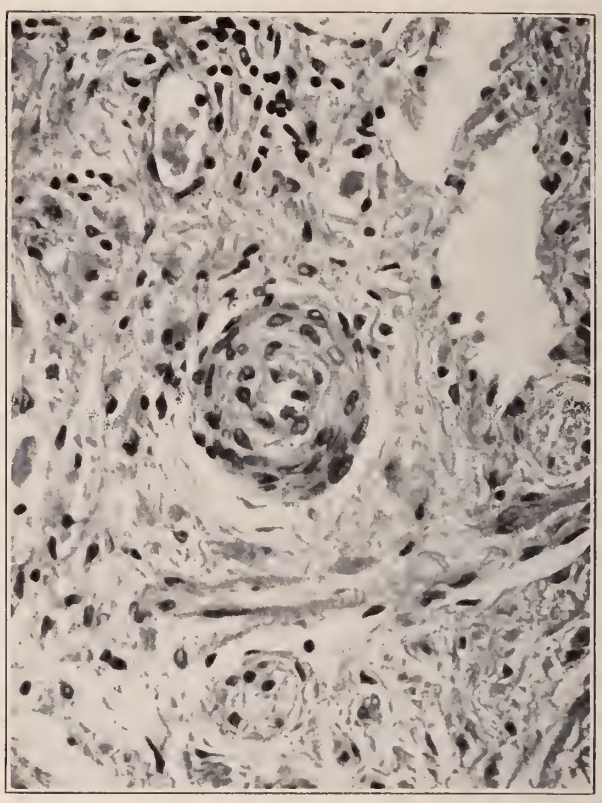

Fig. 6—Chronic, proliferative occluding vasculitis in kidney

and basement membrane type, with a possible contributing factor in the form of a lupus erythematosus. The pathology in the case affected basically the same tissues in many parts of the body—lungs, spleen, liver, kidneys, and bone marrow. In the final evaluation, it may be of importance to place some emphasis on the absence of lesions in the heart since in all of the conditions under consideration in the classification of this case, such lesions have been common or even predominant.

A word about the thrombocytopenia and purpura. It is doubtful that the thrombocytopenia, which, in this case as in the reported cases, was irregular and fluctuating, is of major significance. Even the identification of the components of the thrombi is not clearly established. Whether the thrombi were due to agglutinated platelets is a moot point since the histological identification of platelets in tissue sections is difficult and uncertain even with the aid of histochemical methods. Finally, there may be several explanations for the mechanism of the purpura; to wit, abnormality of number and quality of platelets; vascular pathology; and, in this case, renal failure (uremia).

The clinical pattern of this and similar cases is linked primarily to the disturbance of tissue and organ nutrition brought about by the pathology of the arteries. In this case, as in others, gross or even clearly defined infarctions were absent; and by noting the varied changes in the blood vessels, we can clearly see that the process had passed through several cycles of activity and healing.

The recognition of this condition is being made with greater frequency by clinicians, and the number of cases reported is on the increase. Historically, it is interesting to note that in the first case reported by Moschcowitz in 1925, Dr. E. Libman, who saw the patient in consultation, recognized the situation as a hitherto undescribed disease—a new condition. The etiology is unknown and, along with many other aspects of this syndrome, is wide open for investigation.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

In what type of respiratory depression may the use of N-Allylnormorphine (Nalline) be dangerous?

The effectiveness of Nalline as an antidotal agent to respiratory depression associated with narcotic poisoning from overdosage of morphine, methadone, Dromoran, or heroin, and in instances of neonatal asphyxia when opiates have been used during delivery, is well established on both the laboratory and clinical levels. One should be forewarned, however, that the use of the drug might worsen rather than improve the patient's condition when his respiratory acidosis is unrelated to drug intoxication. S. M. Tenney, J. C. Mithoefer, and D. L. Hutchins,[1] studying the respiration before and after intravenous administration of 2 mg. of Nalline to four normal persons at the University of Rochester, found that the drug lowered the sensitivity of the respiratory center to carbon dioxide by approximately 50 per cent. It was then given in 10 mg. doses intravenously to three patients with pulmonary emphysema and respiratory acidosis and found to cause more insensitivity to carbon dioxide than was present in the control period. The patients also felt drowsy and generally indifferent. In dogs with acute respiratory depression from carbon dioxide narcosis, Nalline had no effect on respiratory ventilation. At the very least, therefore, this study fails to support the contention that Nalline primarily stimulates the respiratory center under all circumstances, for even in low dosage in the normal individuals it was a respiratory depressant.

What old-fashioned drug has recently been gratifyingly vindicated?

The answer is aspirin. In England, a joint committee of the Medical Research Council and the Nuffield Foundation has reported[2] a comparison of results with cortisone and aspirin in the treatment of early cases of rheumatoid arthritis. Cortisone was given to 30 patients and aspirin to 31 in 12-week courses, separated by one week off treatment, for one year. During each course of therapy, cortisone was given in a dose of 300 mg. the first day, 200 mg. the second day, 100 mg. daily from the third to the seventh day, and 50 mg. daily from the eighth to the fourteenth day; individualized dosages of 25 to 200 mg. daily, with graded withdrawal in the twelfth week, were given from the fifteenth to the eighty-fourth day. During each course of therapy, aspirin was given in doses of 6 Gm. daily the first week and 2 Gm. daily the second week; individualized dosages of 1 to 8 Gm. daily, with graded withdrawal in the twelfth week, were administered from the fifteenth to the eighty-fourth day. Observations were made at one week, eight weeks, thirteen weeks, and about one year after the start of the therapy.

The two groups ran a closely parallel course in nearly all characteristics—joint tenderness; range of movement in wrists; strength of grip; dexterity of hand and foot; and, as judged clinically, activity of the disease and functional capacity of the patient. Hemoglobin levels and blood sedimentation rates were slightly more favorably influenced by cortisone, but in no other respect did the two groups differ materially. On each form of treatment the disease was judged, at the end of one year, to be inactive, or only slightly active, in about three-quarters of the patients; and on each treatment two-fifths of the patients were capable of normal work and activity.

Side effects were noted in 19 patients in the cortisone group and 21 in the aspirin group. In the cortisone-treated group, moon face or rubicundity occurred in 11, depression in 5, and euphoria in 4, while in the aspirin-treated group, tinnitus occurred in 11, deafness in 10, and nausea, dyspepsia, or anorexia in 13. For practical purposes, it was concluded that there is little choice between cortisone and aspirin as adjuvants in management of early rheumatoid arthritis.—HARRY BECKMAN, M. D.

(References listed on page 172)

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Tuberculosis Control

As It Looks to Your State Board of Health

MANY people today have the erroneous impression that tuberculosis, as a public health problem in Wisconsin, is licked. This superficial conclusion is based upon the phenomenal drop in the tuberculosis death rate, from 103 per 100,000 in 1910 to 6 per 100,000 in 1953. This viewpoint is also fostered by the increasing number of vacant beds in our tuberculosis sanatoria. The average occupancy in our 1,968 sanatorium beds has dropped in just the last two fiscal years from 90 per cent to 77 per cent, with an alarming increase in the per capita costs of operation. Vacant beds have increased from an average of 211 to 447. Also, 75 beds have been removed from the available list by obsolescence during the same period.

A more careful study of available data easily proves how fallacious and misleading the death rate and sanatorium occupancy figures really are. The drop in the death rate and the lower sanatorium bed occupancy is readily explained by the newer and better methods of treatment, involving the use of new drugs and improved surgical procedures. These changes have resulted in fewer deaths from tuberculosis, shorter periods required for sanatorium care, and almost complete elimination of that group of patients known as "maximum benefit patients," who, because of their advanced disease, were sentenced to live and die in the sanatorium. The increasing and unproved trend toward the home care of tuberculosis may also have reduced the sanatorium patient load.

The danger of contracting tuberculosis is directly related to the number of undiscovered and uncontrolled cases of active tuberculosis in our population. The success of a tuberculosis control program can be measured to a substantial degree by our ability to locate, report, and control these undiscovered cases. In 1910 there were 1,270 cases of tuberculosis reported. In 1942, the year after the State Board of Health began its mobile x-ray screening program, the number of cases of tuberculosis reported increased to 3,292; it remained in the neighborhood of 2,000 cases reported per year through 1950. Since that time the number of new cases reported has gradually decreased, to 1,432 for 1953. Please note that the number of new cases reported, although somewhat lower than in the peak years, has not dropped, proportionately, nearly as much as the death rate. We have been successful in saving the lives of those infected with tuberculosis but have not yet halted the spread of the disease. There are no doubt somewhat fewer undiscovered cases of tuberculosis today than 10 years ago. We find that each year it becomes more difficult to locate the remaining sources of active disease. The relatively large number of new cases which are still discovered each year, over 1,400, points up clearly that the problem is still with us, and cannot be considered solved; and it pinpoints the potential danger in any relaxation of our tuberculosis control measures.

Beginning in 1941 a mobile x-ray case-finding program of the State Board of Health was started; it was financed entirely with grant-in-aid funds of the Public Health Service. In 1945 a special categorical federal grant for tuberculosis was made available from the Public Health Service. This fund reached a peak in 1947 and then rapidly decreased until it was necessary in the 1952 fiscal year to ask for additional assistance from the state. At that time the state took over financing the operation of one of the board's three mobile x-ray units. Federal funds for tuberculosis control have been reduced each year since 1947. In the 1953–1954 fiscal year there appeared to be a distinct possibility that Congress would reduce the tuberculosis grant funds to states to such an extent that it would be necessary to almost completely eliminate the mobile x-ray case-finding program. Last-minute efforts by national organizations were successful, temporarily at least, in restoring the tuberculosis grants and salvaging the states' control programs. It has been stated that this reprieve was granted in order to give those states whose legislatures are not in session until 1955 an opportunity to consider the problem and to determine themselves whether they wished to appropriate funds to continue their tuberculosis control programs.

Of all communicable diseases, tuberculosis has historically been the most unrelenting enemy of all mankind; the enemy is weakening, but the battle is far from won. Looking ahead, if we are to achieve freedom from the danger of contracting tuberculosis, each state must continue its case-finding and tuberculosis control program until tuberculosis becomes as rare as diphtheria and typhoid fever; and even then we cannot relax our vigilance.— E. H. JORRIS, M. D., *Assistant State Health Officer.*

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The Division on Tuberculosis and Chest Diseases wishes to remind all physicians that the State Board of Health is prepared to furnish you with reproductions of 70 mm. films taken of your patients in mobile unit surveys *during the past two-year period.*

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HENRY A. ANDERSON, M. D.
Chairman, Division on
Tuberculosis and Chest
Diseases, State Medical
Society of Wisconsin

Posterior Pituitary Extract for Induction of Labor and Uterine Inertia*

THE Maternal Mortality Study Committee of the State Medical Society of Wisconsin has been increasingly impressed by the injudicious use of oxytocics as a factor in maternal mortality. During their period of 12 months' study there were 66 maternal deaths in the state; of these 65 were thoroughly investigated by the Study Committee. In 26 deaths pregnancy was coincidental; the remaining 39 were truly obstetric deaths. Of these, 15 deaths were judged to be due to ruptured uteri. In six instances of uterine rupture, posterior pituitary extract had been administered either to induce labor or in the first or second stages. In one case the initial dose was 0.25 cc. and in another 11 mm. There was one case of obstructed labor, a transverse presentation, and another of twin pregnancy.

The use of posterior pituitary extract as an oxytocic after the uterus has emptied itself of its contents; in other words, after the third stage of labor, does not concern us here and will not be discussed.

In the first place, it should be remembered that, except for potency, there is little difference between the action on the uterus of posterior pituitary extract and its split products such as Pitocin and additives such as Thytuitary and Thymophysin. Likewise, it should be remembered that there are few drugs which result in such widely varying effects. Tetanic contractions of the uterus have followed the administration of as little as two minims of the drug. It is evident, therefore, that the dosage cannot be standardized and can only be determined by the response of the individual patient. For these reasons it is becoming increasingly accepted that if posterior pituitary extract, or any of its split products, is to be used in labor or as a means of inducing labor, *the drug should be administered by the intravenous, slow drip method or the intranasal pack technic described by Hofbauer and Hoerner.* The advantage of these methods is that if the uterus shows evidence of unusual irritability, the drug can be discontinued promptly and its effects will cease in from two to three minutes. For the intravenous drip method, the commonly accepted dilution is 1 cc. of Pitocin in one liter of 5 per cent glucose in water. A short 22-gauge needle is inserted in the vein and the infusion started at the rate of 20 drops per minute. Depending upon the response of the uterus, this rate may be increased cautiously and gradually to 30 to 40 drops per minute. If the uterus shows signs of unusual irritability or if the fetal heart evidences signs of fetal distress, the infusion should be stopped immediately.

Whenever posterior pituitary extract is to be used as a means of inducing labor or to stimulate contractions in the first or second stages of labor, all contraindications such as pelvic dystocia, abnormal presentations, and multiple pregnancies must be ruled out. *The physician should be in constant attendance throughout the administration of the drug.* This is a responsibility that no nurse, no matter how well trained, should be asked to assume. Many hospitals are setting up this requirement as a "must" in their obstetric routine, and all hospitals must do so if disaster to mother or child or both is to be prevented.

*Prepared for the Study Committee of the Wisconsin Maternal Mortality Survey by John W. Harris, M. D., former professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison. Doctor Harris died on January 14, 1955.

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(Continued from page 167)

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THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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Volume 54 FEBRUARY 1955 Number 2

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« « « EDITORIAL » » »

Interprofessional Meeting

Our retiring president, Dr. H. Kent Tenney, in his report to the House of Delegates suggested that, because of the increasing complexity of medical practice, it is quite apparent that long-range planning as to the integration of services ancillary to those given by the medical profession is of considerable importance. He suggested that an interprofessional institute be set up and hold regular meetings. Such a program would offer an opportunity for establishing a broad base of understanding among the several health professions so that matters of common concern could be given adequate consideration before they reach the "problem" stage.

This suggestion was unanimously approved by the House of Delegates, and they recommended that it be put into immediate action.

The first institute was held on January 28–29 at Madison. Attending were representatives of the Wisconsin Hospital Association, Wisconsin Conference of Catholic Hospitals, Wisconsin Pharmaceutical Association, Wisconsin State Dental Association, Wisconsin State Nurses Association, State Medical Society of Wisconsin, the Department of Public Welfare, the State Board of Health, and the state examining boards in medicine, pharmacy, and nursing.

Enthusiastic discussion took place on a wide variety of health problems whose implications cut across the lines of interest of all who participated. Undoubtedly, this was the first time that the leaders of these professions and agencies in Wisconsin met together in one room for a discussion of their mutual problems in the care of the sick.

We expect great things to come from the continuation of this professional relations effort and look for it not only to smooth out many of the misunderstandings which occasionally creep up among the various health professions, but to set the pace for greater progress in the total care of the patient.

Prevention of Gonorrheal Ophthalmia

Silver nitrate has been used in 1 per cent solution for the prevention of ophthalmia neonatorum since 1880. Blindness due to gonorrheal infection was common at that time.

Wisconsin had no exemption from this infection and its resulting blindness. The State Board of Health approved a rule requiring the instillation of 1 per cent silver nitrate solution in the eyes of all newly born children in 1909; and the legislature, in 1913, made it compulsory. Since then the Board has distributed the silver nitrate to physicians and hospitals in convenient-to-use ampules. The procedure became universal practice by physicians and midwives, and today there is hardly a physician who has seen a case of ophthalmia neonatorum. The average age of applicants for aid for the blind is 60 years, and of the recipients, 65 years. The chief causes of blindness among these applicants and recipients are cataracts, glaucoma, diabetes, and accidents of various kinds.

Now that several antibiotics, particularly penicillin, have been shown to be effective for the cure of gonorrhea, it is being proposed that these agents be used as a substitute for silver nitrate or that the practice of prophylactic treatment be discontinued and the law requiring it be repealed. Antibiotics reported in use are penicillin, Terramycin, and Aureomycin, ophthalmic ointments or 2,500 Oxford units of penicillin per cc. in normal saline, refrigerated and used within a week. Some states, while still continuing the use of silver nitrate, are conducting experiments with antibiotics.

The apparently prevalent opinion that gonorrhea is a disappearing disease cannot be supported with facts. Last year there were nearly 250,000 cases reported in the United States. In Wisconsin, nearly 1,000 cases were reported, and throughout the country there is indication that this infection is on the increase. When we consider that there is poor reporting of cases of the disease, it would seem likely that the total number of cases is much higher than the reported incidence. And, further, since the diagnosis of gonorrhea has not been greatly improved in recent years, it is not unlikely that many cases are not recognized, particularly chronic cases. The smear technic is fairly reliable in cases of urethritis in men, but in chronic cases it loses much of its reliability; and it is entirely unreliable in women, particularly in chronic cases.

There are still other valid objections to substituting a new method for one that has been proved through the years to be almost a perfect preventive measure. One of these is the unstable quality of penicillin, the most widely advocated substitute at present. Though the largest number of babies are born in hospitals in Wisconsin, the preservation of unstable solutions and the application of antibiotics in ointment offer hazards that are not inherent in using silver nitrate. And, more important, none of the methods of using antibiotics has been tried sufficiently to prove its effectiveness.

Silver nitrate in 1 per cent solution dropped into the eyes of newly born children is a safe procedure —no child ever lost his eyesight because of this prophylactic treatment—and it prevents gonorrheal ophthalmia. The mild conjunctivitis that sometimes results is an inconsequential development compared to the invaluable protection which the procedure confers. In Wisconsin, we should take a dim view of any change in the agent used to prevent gonorrheal ophthalmia or the law which requires its use. The loss of sight by one person is too high a price to pay for this experiment, especially since the present agent, silver nitrate, has proved to be almost 100 per cent effective.—W. D. Stovall, M. D.

BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the first half of 1955 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who come within the state's definition of a crippled child. It is preferred that referral be made by the family physician; but when this is not feasible, arrangements may be made by writing to the Bureau. Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons desiring clinic services. Medical referral forms are made up for the individual clinics, so requests should specify for which clinic forms are wanted.

Families who return the signed referral form will be notified of the day and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child; and if the public health nurse believes that the child referred to the clinic for orthopedic reasons is also in need of other services, the Bureau asks that it be notified of the fact.

Marinette	March 2
Manitowoc	March 3, 4
Kenosha	March 9, 10
Racine	March 16, 17
Green Bay	March 24, 25
Eau Claire	March 31, April 1
Wausau	April 6, 7
Sheboygan	April 13, 14
La Crosse	April 19, 20, 21, 22
Superior	April 27, 28
Fond du Lac	May 11
Appleton	May 12, 13
Chippewa Falls	May 19, 20
Rhinelander	June 1, 2
Lancaster	June 16
Darlington	June 17

Inquiries concerning these clinics may be addressed to The Bureau for Handicapped Children, 146 North, State Capitol, Madison 2, Wisconsin.

. . . . THE PRESIDENT'S PAGE . . . .

FOR the past 25 years or more, there has been a continuous and determined effort on the part of powerful influences in the federal government to establish national compulsory health insurance, and an equally determined effort to prevent this by those who believe in free enterprise.

Blue Shield was created by the medical profession because it realized that the application of the insurance principle seemed to be the logical method of meeting medical care costs and that, with proper understanding and leadership, medicine, and American society in general, was capable of solving this problem by voluntary means.

Years ago, the physician taking care of the sick carried in his bag all the equipment that seemed necessary for diagnosis and treatment. But times have changed. The modern physician has to have a long and expensive course of study. Equipment for diagnosis and treatment is costly. He has to have nurses and technicians to help him. The new drugs are as expensive as they are wonderful. The modern hospital is an additional factor contributing to what is known as the high cost of medical care.

In a recent survey by the Social Security Administration covering 1948 to 1953, it is estimated that, of the costs of health care, physicians' bills accounted for 28.6 per cent, hospital bills 29 per cent, medicine and appliances 22 per cent, dental fees 9.6 per cent, other professional services 5.7 per cent, and health insurance 4.9 per cent. Physicians' bills accounted for less than a third of all private medical costs. In the public mind, however, when medical costs are discussed, all medical bills are thought of as doctor bills.

It is true that it is the physician who admits the patient to the hospital and decides when he is able to leave. It is the physician who selects the laboratory, x-ray, and other technical services that he deems necessary in each case. It is also he who prescribes the drugs that he believes the patient should have.

If we are to make the voluntary system work, it is the duty of every practicing physician, every county medical society, and the State Medical Society to see to it that there is no waste of our medical resources. A better knowledge of Blue Shield, a closer relationship of every physician with it, a better education of the policyholder by the physician as to the extent of his coverage, will all help.

We make no compromise on medical care. Every patient is entitled to the very best possible care necessary and available. That is one of the main reasons why the control of Blue Shield must remain in the hands of the medical profession.

It is important, however, that all of us take a greater interest in what our Blue Shield plans are trying to accomplish. The voluntary health insurance movement is in reality a test of democracy itself.

Arthur J. McCary M.D.

Society Proceedings

Ashland–Bayfield–Iron

A meeting of the Ashland–Bayfield–Iron County Medical Society was held on January 5 at the Menard Hotel, Ashland. Eleven members of the society were present.

Dr. Richard Segnitz of Milwaukee spoke on "Hernia in Infants and Children," and a short business meeting followed.

Barron–Washburn–Sawyer–Burnett

The Barron–Washburn–Sawyer–Burnett County Medical Society held its annual meeting on December 14, 1954, at the Elks Club, Rice Lake. The following officers were elected for the new year:

President—*Dr. N. A. Eidsmoe*, Rice Lake
Vice-President—*Dr. L. J. Olson*, Spooner
Secretary–Treasurer—*Dr. F. H. Goetsch*, Spooner
Censor—*Dr. A. G. Johnson*, Rice Lake
Delegate—*Dr. J. R. Guy*, Barron
Alternate Delegate—*Dr. R. C. Thompson*, Cumberland

On January 11, Dr. Titus Bellville, Minneapolis obstetrician, addressed the group at its meeting at the Elks Club, Rice Lake.

Brown–Kewaunee–Door

The annual business meeting of the Brown–Kewaunee–Door County Medical Society was held on December 9 at the Elks Club, Green Bay. Dinner was served at 7:00 p.m.

The following Green Bay physicians were elected officers:

President—*Dr. James W. Nellen*
President-Elect—*Dr. Louis Milson*
Vice-President—*Dr. James F. McDermott*
Secretary–Treasurer—*Dr. George M. Shinners*
Censor—*Dr. R. W. Kispert*

On January 13 at the Elks Club, Green Bay, a dinner meeting of the Society was held. *Dr. Karl Beck*, director of diabetic service for Children's Hospital, Milwaukee, and officer in the National Diabetic Association, was the guest speaker. He spoke on "Diabetes in Children." Fifty-two members attended the meeting.

Dane

Members of the Dane County Medical Society met at 8:00 p.m., December 14, at the Madison Club, Madison, to hear a discussion of matters considered by the House of Delegates of the State Society at its October meeting. The discussion was presented by *Drs. H. Kent Tenney, Jr., N. A. Hill, T. W. Tormey, Jr., C. W. Stoops, Jr., A. A. Quisling, and Robin Allin.*

At its meeting on January 11 at 8:00 p.m. at the Madison Club, the society heard an address by Mr. E. J. Holman, executive secretary of the Judicial Council of the American Medical Association. Mr. Holman spoke on "Medical Ethics."

Dodge

On October 28, 1954, twenty members of the Dodge County Medical Society met at the Lutheran Hospital, Beaver Dam, to hear an address by Donalee Tabern, Ph. D., of the Abbott Laboratories Research Department. His paper was entitled "Radioactive Isotopes in Modern Medicine."

The annual election of officers was held by the society when it met on November 18, 1954, at St. Joseph's Hospital, Beaver Dam. The following physicians were elected:

President—*Dr. Thayer C. Davis*, Beaver Dam
Secretary–Treasurer—*Dr. Richard A. Knudson*, Horicon

Dr. Leonard W. Schrank, Waupun, alternate delegate to the House of Delegates of the State Medical Society, reported on the October meeting of the House in Milwaukee.

Eighteen members of the society attended this county meeting.

The annual Christmas party of the society was held on December 11 at the Elks Club in Beaver Dam. Members and their wives attended.

Dr. Sidney Orth, professor of anesthesiology at the University of Wisconsin, spoke briefly and introduced two resident physicians, Dr. Renaldo Barote from Corrantes, Argentina, and Dr. Enrico Metzia from Rome, Italy. Both resident physicians addressed the society and its guests.

Douglas

On December 22, 1954, members of the Douglas County Medical Society and their wives met at St. Mary's Hospital, Superior, for a testimonial dinner honoring *Dr. Charles Giesen* of Superior, who has completed 50 years of continuous practice in Superior and Douglas County. Dinner was served by the sisters of St. Mary's Hospital. Master of ceremonies was *Dr. James McGill* of Superior.

A champagne toast to Doctor Giesen was proposed by his son and partner in practice, *Dr. Conrad Giesen.*

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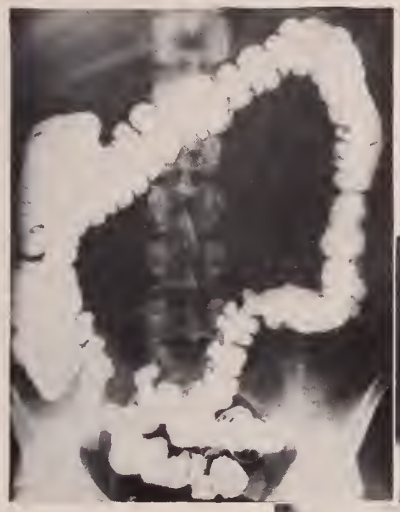

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Fond du Lac

The January meeting of the Fond du Lac County Medical Society was held at the Elks Club, Fond du Lac, on January 27. Dinner was served at 7:00 p.m.

Dr. Henry I. Okagaki, instructor in orthopedic surgery at the University of Wisconsin Medical School, spoke on "The Painful Shoulder Syndrome." A business meeting was also held.

Grant

Election of officers of the Grant County Medical Society was held when the society met on November 18, 1954, at the City Hall in Lancaster. Those elected were:

President—*Dr. John J. David*, Cassville

Vice-President—*Dr. John W. Conklin*, Platteville

Secretary-Treasurer—*Dr. H. W. Carey*, Lancaster

WILSON CUNNINGHAM

A report was made on the county's vaccination program, and the Grant County rescue squad was discussed.

Twenty-four members present heard a talk by Dr. J. C. Painter of Dubuque, Iowa, who spoke on "Clues Leading to the Early Discovery of Tuberculosis." He discussed changes in therapy of pulmonary tuberculosis in the past 30 years.

Dr. Wilson Cunningham of Platteville was honored for his long-time service in the voluntary tuberculosis control movement in the state. Recognition included a citation and medallion from the Executive Committee of the Wisconsin Anti-Tuberculosis Association. They were presented by *Dr. A. A. Pleyte*, Milwaukee, medical director of the Association. The citation read as follows:

> "To Wilson Cunningham, M. D.—A busy general practitioner for a lifetime in a wide area of rural Wisconsin, Dr. Wilson Cunningham has also served his state well as a past president of the Wisconsin State Medical Society and as an early and long-time director of the Wisconsin Anti-Tuberculosis Association.
>
> "It is characteristic of Dr. Cunningham's leadership that the Platteville Municipal Hospital, of which he is chief of staff, is one of the relatively few rural-area hospitals in Wisconsin which has set up a program for routine x-raying of hospital admissions."

Green

The Green County Medical Society met at the Swiss Wheel Restaurant at Monroe on January 11, at which time officers for the new year were elected. They include:

President—*Dr. J. A. Schindler*, Monroe

Secretary-Treasurer—*Dr. Dwain Mings*, Monroe

Delegate—*Dr. W. D. Stovall, Jr.*, Brodhead

At this meeting, the physicians viewed a film on recent advances in the treatment of hypertension. The medical society, by unanimous vote, recorded itself in favor of fluoridation of water.

Green Lake–Waushara

At a meeting of the Green Lake–Waushara County Medical Society at the Hotel Whiting, Berlin, December 16, 1954, the following officers were elected for the new year:

President—*Dr. A. J. Wiesender*, Berlin

Vice-President—*Dr. F. G. Slattery*, Wautoma

Secretary-Treasurer—*Dr. Grant Stone*, Berlin

Censor—*Dr. V. J. Taugher*, Berlin

Delegate—*Dr. Russell Pelton*, Markesan

Alternate Delegate—*Dr. L. S. Shemanski*, Wautoma

All members of the society were present to hear the program presented by *Dr. Robert Schilling* of the University Hospitals, Madison, who spoke on "The Interpretation and Application of Laboratory Procedures in Anemia." *Dr. R. E. Garrison* of Wisconsin Rapids discussed the Blue Shield insurance program.

Kenosha

A panel discussion on alcoholism was presented to the Kenosha County Medical Society at its meeting on December 9, 1954, at the Elks Club, Kenosha. Mr. Richard Dunn, co-founder of Washington Hospital, Chicago, and members of Alcoholics Anonymous from Chicago, Waukegan, and Kenosha presented the discussion.

At the January 6 meeting of the society, also at the Elks Club, election of officers was held. Those elected were:

President—*Dr. Leif H. Lokvam*

President-Elect—*Dr. John T. Garren*

Secretary-Treasurer—*Dr. Helen Binnie*

Delegate—*Dr. David Goldstein*

Alternate Delegate—*Dr. Louis Olsman*

All of these physicians are from Kenosha.

Members of the society also paid tribute to Norman LeWand, police officer, by presenting him with an official commendation and a $100 savings bond. Mr. LeWand rescued a drowning man on Christmas Eve by plunging into the frigid water of the Kenosha harbor.

Forty-two members of the society were present at this meeting.

Manitowoc

The Manitowoc County Medical Society held its annual Christmas party for members and their wives on December 16, 1954. The party was held at the Hotel Manitowoc, Manitowoc, at 6:00 p.m.

On January 20, the society heard an address by *Dr. Francis J. Millen*, assistant clinical professor of neurology at Marquette University School of Medicine. He spoke on "Headaches."

Marathon

The Marathon County Medical Society met at the Wausau Club, Wausau, on November 30, 1954. At that time *Dr. W. T. Becker* of Wausau assumed the chair as president.

New officers elected for 1955 were: President-Elect, *Dr. E. B. Brick*, and Secretary–Treasurer, *Dr. J. V. Flannery*, both of Wausau.

Marinette–Florence

New officers for 1955 elected by the Marinette–Florence County Medical Society are:

President—*Dr. P. R. McCanna*, Marinette
Vice-President—*Dr. J. R. Rogers*, Oconto
Secretary—*Dr. K. G. Pinegar*, Marinette
Delegate—*Dr. Charles E. Koepp*, Marinette
Alternate Delegate—*Dr. J. W. Boren, Jr.*, Marinette

All members of the county society had remitted their 1955 dues to the State Society prior to January 20, thus giving the society the record of being the first to pay its dues in full.

Milwaukee

At the meeting of the Medical Society of Milwaukee County on November 11 at the Milwaukee Athletic Club, Henry S. Reuss, Democratic representative from Milwaukee's Fifth District to the U. S. House of Representatives, addressed the group. About 200 physicians attended the meeting.

The annual dinner meeting of the society was held on December 9 at the Athletic Club; at this time officers were elected. *Dr. D. V. Elconin* took office as president at this meeting. Officers elected were:

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Secretary—*Dr. George S. Kilkenny*
Treasurer—*Dr. Donald S. Thatcher*
Member of the Board of Directors—*Dr. J. G. Garland*
Members of the Credentials Committee—*Drs. W. J. Houghton and M. J. Lustok*
Delegates—*Drs. A. J. Baumann, J. B. Wilets, R. F. Purtell, S. L. Chojnacki, P. J. Niland, A. G. Martin, D. M. Willson, John Beffel, and S. A. Morton*
Alternate Delegates—*Drs. R. A. Frisch, R. E. Callan, D. W. Ovitt, S. E. Zawodny, R. T. McCarty, M. C. F. Lindert, C. M. Schroeder, and E. M. End.*

Dr. Nicholas P. Dallis of Toledo, Ohio, creator and director of the comic strip, "Rex Morgan, M. D.," under the pen name of Dal Curtis, entertained the members. He was aided by two artists who draw the strip, Marvin Bradley, Barrington, Illinois, and Frank Edgington, Toledo.

At the meeting of the society held at the Athletic Club on January 13, Dr. W. Paul Holbrook of Tucson, Arizona, spoke on rheumatic diseases. Doctor Holbrook is director of research at the Southwestern Clinic and Research Institute at Tucson.

On February 10 the members met at the Athletic Club to hear a symposium on "The Management of Acute Myocardial Infarction," sponsored by the Lucy Ann Droessel Memorial Fund of the Wisconsin Heart Association.

Guest panelists were Dr. F. Janney Smith, Detroit, physician in charge of the cardiorespiratory division of Henry Ford Hospital; Dr. William Brams, Chicago, Michael Reese Hospital and Northwestern Medical School; and Dr. W. B. Youmans, Madison, Wisconsin General Hospital and the University of Wisconsin Medical School.

Oconto

The Oconto County Medical Society met on December 21, 1954, at the Alamo Club at Stiles. Seven of the ten members of the society attended and heard Dr. Joel Clay of Menominee, Michigan, speak on "Ulcerative Lesions of the Stomach." A discussion period followed.

On January 18, the society met at the Lilac Club, Gillett. Movies entitled "Surgical Management of Primary Hyperthyroidism" and "Carcinoma of the Thyroid" were shown. Six members of the society were present.

Pierce–St. Croix

The Pierce–St. Croix County Medical Society held its monthly meeting at the Hotel Marion in Menomonie on November 16, at which time the

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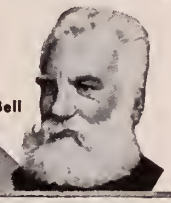

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members were guests of *Dr. A. E. McMahon*, who formerly practiced in St. Croix County. *Dr. K. L. German*, Eau Claire urologist, discussed the latest developments in diagnosis and treatment of "Diseases of the Prostate Gland."

At the short business meeting which followed, plans were developed for assisting local blood drive chairmen in their programs to interest more people in donating blood.

At the meeting held at the Spa in Hammond on December 16, Mr. Earl Thayer, assistant secretary of the State Medical Society, discussed "A Health Improvement Program for Pierce and St. Croix Counties." This program is being started in 1955 in cooperation with local and state health and education agencies.

Dr. F. B. Klaas, East Ellsworth; *Dr. G. J. Hopkins*, Hudson; *and Dr. P. S. Haskins*, River Falls, were appointed to a committee to formulate definite plans for the program.

Dr. E. F. Hill of Spring Valley entertained the members of the society in his new medical building on January 18. The occasion was a dinner meeting at which Dr. Donald Lannin of St. Paul was the guest speaker. His subject was "Orthopedics."

Polk

Fifteen members of the Polk County Medical Society were the dinner guests of *Dr. W. C. Andrews* at the Methodist Church Parish Hall in Frederic on November 18, 1954. Dr. J. Arthur Myers, professor of medicine at the University of Minnesota Medical School, spoke on "The Newer Treatments of Tuberculosis." A round table discussion followed.

In the business session which followed, discussion was given to the ethics of medicine.

The society members and their wives were the guests of *Dr. Stella Burdette* of Balsam Lake at a Christmas party on December 9, 1954, at the Methodist Church. A sound movie on skiing was shown by Mr. Leo Burdette, and gifts were exchanged.

Racine

On November 18, members of the Racine County Medical Society met at St. Luke's Hospital, Racine. Officers for 1955 were elected as follows:

President—*Dr. S. J. Faber*, Racine
President-Elect—*Dr. L. E. Fazen, Jr.*, Racine
Vice-President—*Dr. R. H. Lehner*, Racine
Secretary—*Dr. Eugene Pitts*, Racine
Treasurer—*Dr. E. L. MacVicar*, Racine
Delegates—*Dr. L. O. Mastalir*, Burlington; *Dr. G. J. Schulz*, Union Grove
Alternate Delegates—*Dr. J. D. Postorino*, Racine; *Dr. R. J. Schacht*, Racine

The officers were installed on the occasion of the dinner-dance for members of the society and their wives held on December 2, 1954, at the Racine

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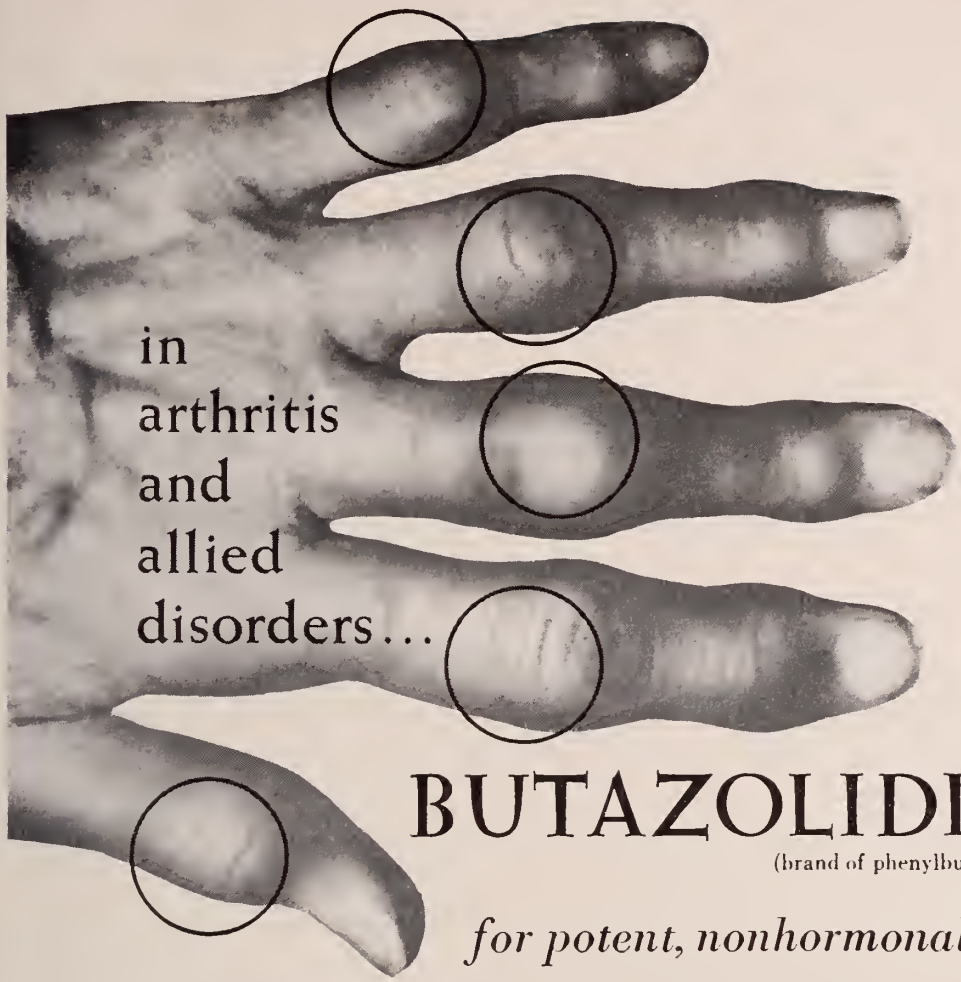

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*MacKnight, J. C.; Irby, R., and Toone, E. C., Jr.: Geriatrics 9:111 (Mar.) 1954.

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Country Club. An open house at the home of the incoming president, *Dr. S. J. Faber*, preceded the occasion.

Richland

At the December meeting of the Richland County Medical Society, the following Richland Center doctors were elected officers for 1955:

President—*Dr. Roy C. Glise*
Vice-President—*Dr. Joseph A. Seidl*
Secretary-Treasurer—*Dr. L. M. Pippin*
Delegate—*Dr. D. J. Taft*
Alternate Delegate—*Dr. R. E. Housner*
Censor—*Dr. K. H. Meyer*

A movie produced by the U. S. Navy and the National Selected Morticians was shown by Mr. Willard Pratt.

Rock

At a meeting of the Rock County Medical Society at Beloit on November 16, *Dr. C. H. Kalb*, clinical allergist of Milwaukee, was the speaker. He discussed "Challenging Allergic Problems in Medical Practice."

Sauk

The annual meeting of the Sauk County Medical Society was held at the Warren Hotel, Baraboo, on December 14, 1954. The following officers were elected for the new year:

President—*Dr. B. E. McGonigle*, Baraboo
President-Elect—*Dr. Gibb Zauft*, Prairie du Sac
Secretary-Treasurer—*Dr. J. J. Rouse*, Reedsburg
Censor (for three years)—*Dr. M. F. Huth*, Baraboo
Delegate—*Dr. J. F. Moon*, Baraboo
Alternate Delegate—*Dr. J. J. Rouse*, Reedsburg

Fourteen of the members were present and heard a talk on "The Unusual in Diabetes," presented by *Dr. Edgar Gordon*, professor of medicine at the University of Wisconsin Medical School.

On January 11, the society met at the Warren Hotel, Baraboo, to hear a talk by Van R. Potter, Ph. D., professor of oncology, University of Wisconsin Medical School, on "Biochemical Studies Directed toward Hematological Treatment of Cancer."

Sheboygan

Election of officers was held at the time of the meeting of the Sheboygan County Medical Society on December 14, 1954. The following were elected:

President—*Dr. R. H. Evers*, Plymouth
Vice-President—*Dr. L. M. Simonson*, Sheboygan
Secretary-Treasurer—*Dr. R. M. Senty*, Sheboygan

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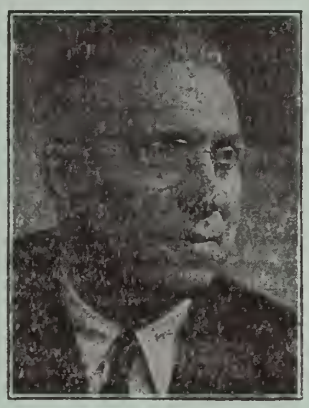
THE MEDICAL FORUM

NAME COMMITTEE TO MEET WITH LEGION ON VETS AFFAIRS

Dr. Middleton



Dr. Weston

VA Names Dean Middleton Chief Medical Director

Madison, Feb. 3.—Dr. William S. Middleton, dean of the University of Wisconsin Medical School since 1935, has been named chief medical director of the Veterans' Administration at Washington, D. C.

Dr. Middleton's appointment, for a 4-year term, was announced by Harvey V. Higley, Veterans Administrator, at Washington. He will assume his new post on March 1, succeeding Vice Admiral Joel T. Boone, who is retiring as VA medical director because of illness.

WAS SCHEDULED TO RETIRE

An internationally recognized authority on blood and cardiovascular diseases, Dean Middleton was scheduled to retire from his University post on July 1, to devote his time to research. His successor, Dr. John Z. Bowers, will assume the post on that date. President E. B. Fred of the University said he will recommend that the Regents grant Dr. Middleton a leave of absence. He also will recommend that the Regents name Associate Dean O. A. Mortensen of the Medical School acting dean until July 1.

In his new post, Dr. Middleton will have charge of the 172 VA hospitals in the country which care for 500,000 patients annually and 105 clinics, serving 140,000 patients each month. The medical service division of the VA has an annual budget of more than $800,000,000.

Commenting on the appointment, Mr. Higley, a Marinette industrialist, described Dr. Middleton as "exceptionally qualified to provide the kind of leadership that will insure a continuation of top quality care for eligible veterans."

Admiral Boone said that under Dr. Middleton, the VA medical program will "go forward on the road of medical advancement."

An internist, Dr. Middleton was chief consultant in medicine of the Allied forces in Europe during World War II. He was awarded the Distinguished Service Medal for his work and was also chosen a fellow of the British Royal College of Physicians for his service.

He has been associated with the veterans medical program in a variety of capacities, beginning in 1922 when he served with the Veterans Bureau as an attending specialist in tuberculosis. At present, he is a member of the National VA Medical Advisory Committee on Education.

A graduate of the University of Pennsylvania School of Medicine, he has been a member of the University of Wisconsin faculty since 1912.

Madison, Feb. 3.—President A. J. McCarey, Green Bay, has announced the appointment of his special committee on veteran affairs to meet with the American Legion, Department of Wisconsin.

The appointment was made at the request of the House of Delegates at its last meeting in October when it asked that the president appoint a liaison committee of three or five members to meet with a like committee of the Wisconsin American Legion to discuss non-service-connected disabilities.

DR. WESTON IS CHAIRMAN

The appointments announced by Dr. McCarey were the following:

- Dr. F. L. Weston, Madison, Chairman
- Dr. F. H. Wolfe, La Crosse
- Dr. J. P. Conway, Milwaukee
- Dr. C. E. Koepp, Marinette
- Dr. S. W. Hollenbeck, Milwaukee
- Dr. A. J. McCarey, Green Bay, ex officio
- Dr. E. L. Bernhart, Milwaukee, ex officio
- Dr. R. E. Galasinski, Milwaukee, ex officio

Dr. McCarey said that the committee will seek a joint meeting with the committee of the American Legion "some time after the middle of February."

NAME LEGION COMMITTEE

James A. Martineau, Oconto, Department Commander, American Legion, has named James F. Burns of Milwaukee, chairman of the Legion's special committee. Others on the Legion committee are the following:

- Frank R. Schneider, La Crosse
- Walter J. McLay, Milwaukee
- Franklin D. McTavish, Oconto
- Dr. E. C. Cary, Reedsville
- Robert G. Wilke, Milwaukee, *ex officio*
- Charles P. Curran, Mauston, *ex officio*
- James A. Martineau

Blue Shield Major Illness Plan Reinsures with Private Carriers

Madison, Feb. 5.—A major illness expense policy providing "full payment" of physicians' services between a deductible and the maximum of $5,000 is being offered by Wisconsin Physicians Service, the Blue Shield Plan of the State Medical Society.

Although the first installation of the program was made last September, a reinsurance agreement was only recently completed. The agreement was negotiated between the State Medical Society and Hardware Mutuals of Stevens Point and Employers Mutuals of Wausau.

Groups of fifty or more are eligible to purchase the major illness plan. Deductibles range from $200 to $500, and the individual maximum benefit is $5,000 per illness. The maximum aggregate benefit for a subscriber and his dependents on account of any one illness is $15,000.

The deductible can be satisfied by covered out-of-pocket expenses or benefits from a basic program.

"FULL PAYMENT" IS UNIQUE

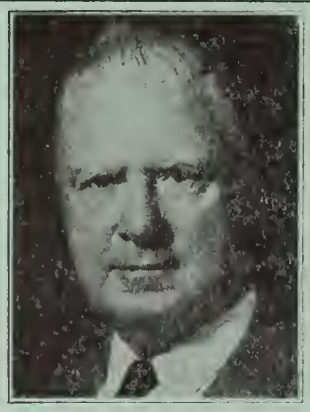
The Wisconsin "full payment" feature is unique among Blue Shield plans which offer catastrophic-type coverage, according to the State Medical Society. The plan will pay 100 per cent of all reasonable charges for professional services of a participating physician. When services are performed by a nonparticipating physician, the plan will pay 80 per cent of the service charges. Nearly 90 per cent of the practicing physicians in Wisconsin are participating.

The Blue Shield major illness expense plan will pay 80 per cent of the charges for other services and supplies prescribed or recommended by the attending physician, including special nursing care, dental services, physical therapy, drugs and medicines, x-ray, laboratory, appliances, oxygen, rental of radium and iron lung, blood, and ambulance service.

The plan may be purchased with or without a basic surgical-medical program. A special Blue Shield rider is available to provide per diem benefits while hospitalized, or the purchaser may elect a catastrophic hospital program available through Blue Cross of Wisconsin.

Rates vary according to size and composition of the group. Wisconsin Physicians Service reports that a typical family rate for a $300 deductible plan in an average group of 100 employees would be in the range of $4 to $6 per month.

Dr. E. M. Dessloch, Prairie du Chien, chairman of the State Medical Society's Commission on Prepaid Plans, said the reinsurance agreement was the first of its kind between a Blue Shield plan and private carriers. He added that "contrary to Mrs. Hobby and the Department of Health, Education, and Welfare, such reinsurance agreements are commonly available among private insurance carriers on a voluntary basis and without the thought or necessity of federal subsidy."



Dr. Tufts

Medical Examiners Elect Dr. Tufts As President

Madison, Jan. 15.—The State Board of Medical Examiners elected Dr. Millard Tufts, Milwaukee, as its president at its January meeting in Madison.

Dr. J. W. McRoberts, Sheboygan, was named vice-president of the board, and Dr. Thomas W. Tormey, Jr., Madison, was re-elected as secretary.

During the meeting, the board took action on a number of problems including those of licensing foreign graduates, uranium tunnel operations, and certification of physical therapists.

The board also held 27 written examinations and 29 oral reciprocity examinations in medicine and surgery, gave nine written physical therapy examinations, and granted seven temporary educational permits.

Concerning the licensing of foreign graduates, the board voted to send a representative to the Congress on Medical Education and Licensure in Chicago, to be attended by American medical school deans and members of the Federation of State Medical Boards.

At that meeting, a proposal will be considered to set up a committee of representatives from the federated board to set standards and to review and evaluate credentials of individual foreign graduates desiring licenses. The committee would then recommend action to the individual board concerned.

The Wisconsin State Board heard a report on the present status of uranium tunnel operations in the state by Deputy Attorney General Stewart G. Honeck and then passed a resolution approving the continued prosecution of tunnels still in operation.

The board also took action on the question of reciprocity for certification of physical therapists, determining that such reciprocity would be given only on the basis of written examinations.

Members of the state board, in addition to Drs. Tufts, McRoberts, and Tormey, include the following: Drs. J. W. Prentice, Ashland; Alvin G. Koehler, Oshkosh; Clifford A. Olson, Baldwin; John A. Schindler, Monroe; and E. C. Murphy, D. O., Eau Claire.

Dr. Stovall Re-elected Welfare Board Head

Madison, Jan. 15.—Dr. William D. Stovall, Madison, director of the State Laboratory of Hygiene, was re-elected chairman of the State Board of Public Welfare at a meeting on January 12.

A past president of the State Medical Society, Dr. Stovall will be serving his sixth term as chairman of the public welfare board.

During its meeting, the board voted to request a formal opinion from the Attorney General concerning the law governing the immunization of children in child day care centers. Christian Science organizations have voiced a protest against children of their belief being immunized at the centers.

The board is drafting a code of standards for the day care centers.

PROPOSE HEALTH PLAN OPTIONS FOR U. S. EMPLOYEES

Washington, Jan. 14.—In a revision of its plan for providing health insurance for federal employees, the Administration has proposed legislation which would offer U. S. employees three options for contributory group health insurance.

In the new program, workers would have a choice of participating in one of the following: (a) a new standard, nationwide plan, administered by the Civil Service Commission, which would offer catastrophic insurance; (b) existing plans sponsored by their own national employee organizations; or (c) local plans offered in their community or through local employee unions or other agencies. Workers could also waive any participation.

CAN CHOOSE BLUE CROSS–SHIELD

Under choice (c) above, the program makes it possible for an employee to choose a Blue Cross–Blue Shield program if he so desires. Regardless of which plan the employee chooses, the Government would contribute part of the cost.

The new program was outlined by President Eisenhower in a special message on Jan. 11. Full details, released the following day by the Civil Service Commission, include the following major provisions:

1. Annual cost of the Government contribution is estimated at $55 million. The U. S. would pay up to one-third of the premium costs with a limit of $1.50 per month for employees without dependents and $4.00 per month for those with dependents. Under the standard national coverage the amounts of Government and employee contributions would be fixed, but the employee's premiums would vary with other types of coverage.

2. The Civil Service Commission would administer the entire program, but would contract with a single insurance company to operate its standard plan. That plan would not become operative unless 600,000 of the 1,800,000 eligible government workers agreed to participate.

Employees could pass up this plan and participate instead in a commission-approved community plan conducted by Blue Cross, Blue Shield, or a group practice plan serving a "significant proportion" of the community.

The head of a federal agency could authorize an insurance company to offer a group health insurance plan to any group under his jurisdiction, if 75 per cent of the group accepted the program.

COMMISSION SETS BENEFITS

3. The standard plan would be straight cash indemnity, based on a schedule of benefits set by the Commission. As proposed these include: up to $12 a day for hospital room with a maximum of 70 days; reimbursement for surgery under a Commission-set fee schedule with a maximum payment of $200 and such fees as adenoidectomy, $30, appendectomy, $100, panhysterectomy, $175; $150 for any one maternity; up to $3 per day for physicians' charges while in the hospital; and a maximum of $50 per year for out-patient expenses such as x-ray and laboratory expenses.

4. Major medical cost protection would be restricted. After exhausting the regular benefits, the policyholder would have to meet the next $100 expenses. After that, however, the standard policy would reimburse him for 75 per cent of the costs up to $2,500. Beyond that figure, he would no longer be eligible, although his eligibility could be restored later by passing a physical examination.

5. After a minimum of 15 years' civilian service, employees who retire could continue under the program by authorizing deductions from retirement checks. An employee who leaves governmental service could also continue under the standard plan at his own expense.

Appoint New Member to Public Policy Committee

Madison, Jan. 15.—Dr. J. P. Conway, Milwaukee, has been appointed to the State Society's Committee on Public Policy for a term of four years.

According to Dr. A. J. McCarey, Green Bay, president of the Society, who announced the appointment, Dr. Conway will fill the vacancy created by the death of Dr. J. A. Enright of Milwaukee, who had been reappointed to the committee at the annual meeting last October.

The committee handles the study of legislative matters pertinent to the medical profession in the state.

NURSES HEAR ROLE IN CIVIL DEFENSE

Madison, Jan. 15.—Dr. Arthur L. Van Duser, Madison, of the State Board of Health, recently gave an illustrated lecture on the role of nurses and other medical personnel in civil defense.

Dr. Van Duser, who is deputy co-director for health services for the State Office of Civil Defense, spoke at a meeting of the Appleton District of the Wisconsin State Nurses' Association.

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Pierce–St. Croix Society Tells of Year-Round Public Relations Plan

River Falls, Jan. 28.—The Pierce–St. Croix County Medical Society has announced a year-round public relations program for 1955.

Five projects are scheduled for the year as a means of establishing the medical profession as the public health leaders of the community as well as improving public understanding of important health matters and providing direct medical and health service to the people of these two counties.

Arrangements for a school health conference, to be held at River Falls State College in cooperation with the Wisconsin School Health Council this spring, are under the direction of Drs. C. A. Olson, Baldwin, chairman; M. G. Anderson, Hudson; and C. W. Horswill, River Falls.

Dr. J. H. Armstrong, New Richmond, is chairman of a committee to carry out the Salk polio vaccine program among first and second grade children late this spring. Drs. Eldon Hill of Spring Valley, and P. W. Limberg of Glenwood City, will also serve on the committee.

Dr. F. B. Klaas, East Ellsworth, is chairman of a committee on emergency medical service and public health education. Other members of the committee are Drs. P. S. Haskins, River Falls, and G. J. Hopkins, Hudson.

The county-wide immunization program is under the direction of a committee composed of Dr. Haskins as chairman, and Drs. A. R. Aanes, Ellsworth; and M. A. Cornwall, Hudson. They will also seek to obtain the services of a public health nurse in the county.

The blood donor program for the area will be under the direction of Drs. G. E. Bourget, Hudson, chairman; R. R. Davis, New Richmond; and G. M. Sargeant, Baldwin.

Psychologists Ask SMS Aid in Preparing Certification Bill

Madison, Jan. 15.—The Wisconsin Psychological Association has asked for State Medical Society cooperation in the preparation of legislation aimed at the certification or licensure of clinical psychologists.

At a meeting between representatives of the Wisconsin Psychological Association and members of the State Medical Society's Subcommittee on Clinical Psychologists of the Division on Nervous and Mental Diseases, it was suggested that the psychologists are currently interested in a certification bill which would certify not only clinical psychologists but all psychologists. It was suggested that such legislation was designed primarily for the protection of the title of such individuals and that qualifications would be based upon examination by an appointed board.

Representing the Society's subcommittee were Drs. E. D. Schwade, chairman, and Chester Wade, both of Milwaukee, and Hans Reese, Madison. Drs. Fred W. Billingslea, Tomah; S. H. Freeman, Milwaukee; C. S. Bridgeman, Madison; D. W. Dysinger, Madison; and H. A. Page, Madison; represented the Wisconsin Psychological Association.

Although the American Psychological Association and the American Psychiatric Association appear to have agreed on a legislative moratorium for a 2-year period, Dr. Billingslea stated that many of the state psychological societies did not go along with the moratorium idea.

Dr. Billingslea pointed out that educational developments in the field of psychology have taken place so rapidly that there is no way of determining who is qualified, and there are many individuals who are setting themselves up as psychologists with very inadequate training. He added that there is no legal definition of psychology and no independence of practice is recognized.

Dr. Billingslea admitted that certification would ultimately lead to licensure. He stressed the fact that the psychologists want to use this means to "clean house of poorly trained individuals holding themselves up as providing services of a psychologist."

Dr. Freeman indicated that there is a large amount of quackery in the field of psychologic testing and evaluation and cited cases in Milwaukee where a large number of persons associated with industry are supposedly rendering psychologic testing service but have actually had very little training in this field.

Dr. Schwade and Dr. Reese urged the development of more adequate legislation than exists in such states as Minnesota and several others where certification laws for psychologists have been in existence for some time.

Representatives of the subcommittee and the psychologists' association plan further studies and meetings before the final development of proposed legislation.

AMA Committee Visits Osteopathic Colleges

Chicago, Jan. 31.—The AMA committee studying the relations between osteopathy and medicine began making on-campus visits to five of the six schools of osteopathy at the end of January.

According to Dr. John W. Cline, San Francisco, chairman of the committee, the visits will be carried out by committee members and several participating deans. The committee's final report is expected to be ready for submission next June.

The committee, created by the AMA House at its June, 1952, meeting, includes the following members in addition to Dr. Cline: James Z. Appel, Lancaster, Pa.; F. J. L. Blasingame, Wharton, Tex.; Edwin S. Hamilton, Kankakee, Ill.; and Julian Price, Florence, S. C.

Full-Length Book Available on Medical Public Relations

Chicago, Jan. 15.—The first full-length book on medical PR, *Public Relations in Medical Practice*, has recently been published. Its author is James E. Bryan, administrator of the Medical–Surgical (Blue Shield) Plan of New Jersey, and formerly executive secretary of the Medical Societies of the County of Westchester (N. Y.), the County of New York, and the State of New Jersey.

Forward to the book is by Dr. Louis H. Bauer, past president of the AMA. Topics covered in its ten chapters outline the doctor's relationship with the following: patients, office and staff, colleagues, community, medical society, hospital, prepaid medical care plans, fees, and himself. The book is published by Williams & Wilkins Co., Baltimore, at $5.00.

Society Seeks Improvement In State Commitment Laws

Madison, Feb. 1.—A major portion of the State Medical Society's legislative program for 1955 is its effort to make substantial amendments to Chapter 51 of the Wisconsin Statutes relating to commitment laws.

The Society's Division on Nervous and Mental Diseases, under the chairmanship of Dr. E. D. Schwade of Milwaukee, has for several years been concerned over the problems involved in the commitment of mentally ill persons. Its long and detailed investigations, in cooperation with the Wisconsin County Judges Association and the State Department of Public Welfare, have finally resulted in proposals for legislative change.

Among the proposals being made by the Society are the following:

1. The epileptic, as a person suffering from one of several diseases characterized by lapses of consciousness, should not be singled out for special treatment and, alone among others similarly situated, be classified with the mentally ill, deficient, defective, and infirm.

PROPOSE CHANGES IN TERMS

2. The term "certification" should be substituted for the term "commitment" wherever it appears in the statutes. This recommendation is not considered a matter of semantics. In 1947, the term "hospital" was substituted for "insane asylum" with lasting and meritorious effect. The same stigma applies to "commitment" in the opinion of the Society.

3. The term "mental disease" should be utilized and should include mental "disturbances," "infirmity," "illness," "deficiency," and "insanity" where they appear in Chapter 51. Those sections of the statutes with general application to the certification of the mentally diseased should be amended to utilize the medically acceptable term "disease." However, in certain sections of the statutes where some administrative function is served through the use of the other terms, there will be no substitution.

Dr. Keith Keane, Sheboygan, has been chairman of the Subcommittee on Commitment Laws which did the basic work leading to the proposed legislation. Others on the committee are: Drs. Walter Urben, Madison; J. T. Petersik, Winnebago; Owen Clark, Oconomowoc; Henry Veit, Milwaukee; Roland Jefferson, Milwaukee; Michael Kasak, Wauwatosa; and Dr. Schwade, ex officio.

The committee believes it is time to re-evaluate the statutes in relation to the epileptic and change the terminology which reflects an archaic relationship between this specific disease and mental disease. The committee believes that if the epileptic with established mental disease is to be committed to a mental hospital, he should be committed on the basis of his mental affliction and not on the basis of being an epileptic.

The committee is also recommending that special legislation be introduced to change the statutes so that it will no longer be required to report epilepsy to the State Board of Health.

The present statutes provide that the sheriff or any other police officer may take into temporary custody any person who is violent or who threatens violence and who appears irresponsible and dangerous. However, many police officers are reluctant to take custody of dangerous persons fearing possible legal action against them charging false arrest. Therefore, the Society is proposing that the statutes provide for a compulsory application for detention. The application, according to the Society proposal, must be presented to the county or district judge of the county in which the patient is found. It is believed that this will avoid the possibility of a person being detained against his will without the fact of his detention coming to the attention of the judge.

The Society's proposed changes in the commitment laws also place greater emphasis on eliminating the use of jails as a place of temporary custody for such patients. The Society's proposal asks that "temporary custody or detention shall be in a hospital where there are suitable psychiatric facilities and which has been approved by the judge or, if there is no such hospital, in a place of temporary detention until arrangements can be made for transportation to another facility where psychiatric services are available."

Board of Health Appoints Civil Defense Assistant

Madison, Jan. 25.—Theodore Noe, Monteo, N. C., began his duties as assistant co-director of health services in civil defense with the State Board of Health on January 24.

According to the announcement of the appointment by the Board of Health, Mr. Noe will assist the state health officer in developing a strong and continuing civilian defense health and medical service program throughout the state. His work will include completion of recruiting and organization of mobile medical casualty teams, initiation and coordination of blood procuring programs for emergency needs, and development of plans with hospitals for the care of large numbers of disaster victims.

Mr. Noe, who is 37, graduated from East Carolina Teacher's College, Greenville, N. C., and received his public health training at the University of North Carolina, Chapel Hill. He has been director of the Near East Foundation's health program in Iran.

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COUNTY SOCIETY ASSISTS MASS TEST PROGRAM

By MRS. HAROLD RUSSELL
Chairman, Committee on Skin-testing
Rock County Tuberculosis Association

At its April, 1954, meeting the Rock County Tuberculosis Association made the decision to conduct a mass skin-testing program for all school children, grades 1 through 12, in the county.

In carrying out such a program, the first step was to gain the cooperation of all health and educational groups which would have an interest in the project. Thus, a dinner meeting was held with the following representatives.

Dr. Jack D. Schroeder, Janesville, represented the Rock County Medical Society. Attending from the tuberculosis association were Mrs. Eugene Winger, secretary and chairman of the program planning committee; Mrs. George Schmedley and Mrs. Lawrence Matske, Board members; Mrs. Mary Quinn, educational advisor; and myself.

The other representatives at the dinner were Gladys Salter, R. N., Rock County Health Center; Agnes Jensen, R. N., of the State Board of Health TB Department; Irene Kimel, R. N., district supervisor for the State Board of Health; Don Upson, county superintendent of schools; and Dr. Edward K. Steinkopff, medical director, and Iva Hartman, R. N., superintendent, Pinehurst Sanitorium.

GROUPS PROMISE SUPPORT

Full support was given by all the groups represented at this meeting, and plans were made to conduct the mass skin-testing program. Committees were appointed.

Drs. Steinkopff and Schroeder were to contact doctors for their support and for carrying out the actual testing. Miss Hartman and Miss Salter would be responsible for drawing up permit slips to be signed by the parents. They were also to gather the necessary materials for doing the testing, such as syringes, needles, cotton, alcohol, and they were to obtain volunteer nurses to assist the doctors.

Mrs. Quinn would act as educational advisor for the program and would handle the publicity. Mr. Upson assured the association of the full support of the teachers in the area.

I was to be responsible for arranging educational meetings, contacting volunteers to assist at the testing centers, and to arrange for the centers to be set up and the dates for the testing.

Mrs. Russell

Active in community work for many years, Mrs. Russell is vice-president of the Rock County Tuberculosis Association. At present, she is State Chairman of the Wisconsin Farm Bureau Women. Commenting on the cooperation of the Medical Society, Mrs. Russell said: "The result of our over-all program is gratifying and thanks go to the many people who helped make it a success—doctors, nurses, teachers, parents, and others."

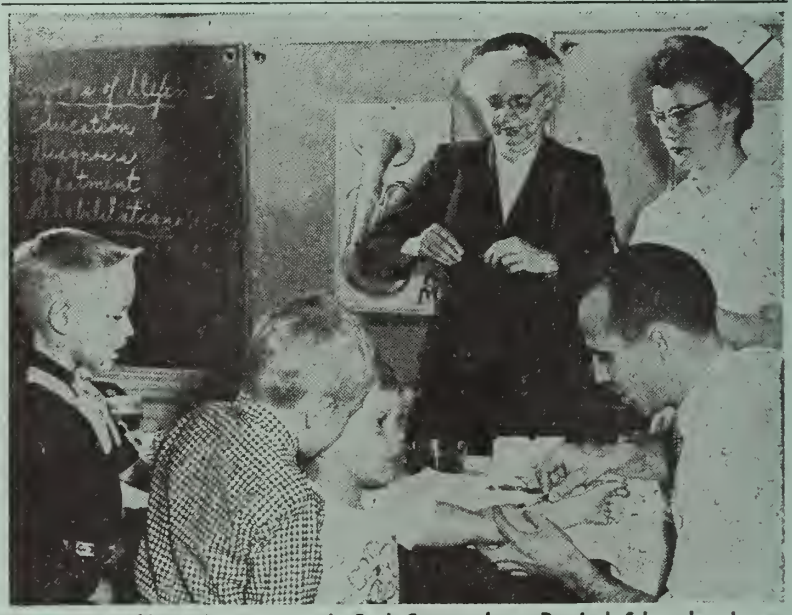
Since the public had to be informed of the program, we began by sending a letter from the association to its local directors asking for a list of presidents of all organized groups in their respective townships. The response was wonderful, providing a list of over 100 organized groups.

A letter was then mimeographed and sent to each president, telling about the program and its sponsors. A questionnaire, to be returned to the association, was included asking if the group would be interested in having a film and a talk on the program presented.

Again, the response was overwhelming. Over 100 meetings were held from August 20 to November 15. Interest ran high and people were eager for information.

These meetings were well worth the time and effort, we felt. In tabulating the percentage of children who participated in the skin-testing program, a consistently higher percentage was found to have participated wherever an educational meeting had been held.

After all the educational work was completed, the matter would be in the hands of each parent. Without their consent and their signatures on the permit card their child brought home from school, the program would be a failure.



Scene during skin-testing program in Rock County shows Dr. Jack Schroeder, Janesville, medical society chairman for the program, giving test to second grader, Philip Simmons, at Roosevelt School in Janesville, assisted by Ida Hubbard, R. N. (left), Janesville City Health Nurse, and Miss Charlotte McKeown, student nurse at Mercy Hospital. Waiting in line are other second graders (left to right) Raymond Selchert and Jeff Statz.

A letter to each parent was prepared. It formed the basis of an informational envelope which also included the permit card and literature on tuberculosis obtained from the Wisconsin Anti-Tuberculosis Association with which the RCTA is affiliated. These envelopes—15,000 of them—were "stuffed" by the Consolidated Homemakers, the Rock County branch of the Agricultural Extension Service, and by members of the Janesville P.T.A.'s.

Mrs. Quinn, Miss Hartman, and I delivered these envelopes to each rural teacher in the county and to the superintendent of each city school. The teachers then gave one to each student to take home to his parents.

In another method of publicizing the program, a booth was set up at the Rock County 4–H Fair. It was a unique exhibit, showing the testing centers and the dates when the testing would be done at each.

PARTICIPATION IS HIGH

The testing started on October 11 at 8:00 a.m. With volunteers, nurses, doctors, and assistants ready and waiting, it would soon be evident how many were going to respond to the program—and we were swamped! Finishing the first tests, and amazed and happy at the turnout, we hurried to the next testing center, scheduled to begin at 10:30. Arriving a few minutes late, we found the yard full of cars and the building full of children waiting for what they thought would be a terrible shot. Many were surprised to find how simple it really was.

For four weeks the testing went on; the greatest number of tests done in one day was 1,651 at the Janesville High School. Simultaneously, Dr. Steinkopff read all the tests, assisted by either Mrs. Quinn or myself. Each student was given an explanatory letter telling him the results of his test.

Finally came the tabulation of the results. In the rural areas, 5,470 students were tested and 130 positive reactions were found. In Janesville, 5,318 were tested and 172 of these had positive reactions. In addition, 142 preschool children were given tests with 1 positive reaction showing up, and 508 adults—volunteer helpers—were tested with 78 showing positive reactions.

Participation in the program was 90 per cent. Many of the absentees will be followed through and many of the ones not participating had had previous tests.

POSITIVE TEST REACTIONS
Janesville Schools—Partial Study

Age	Total Number	Boys	Girls
16	31	23	8
15	23	12	11
14	23	11	12
13	15	7	8
12	27	16	11
6	12	4	8
5	12	4	8
4	1	0	1
Totals	144	77	67

Following this program up with x-rays is a continuous program which will be carried out by the family doctor and the local public health nurses.

The organizational and educational groundwork has been laid, also, for the coming of the mobile x-ray unit for testing adults in the county.

What did the association hope to gain with the skin-testing program? It was felt that if even one positive case of tuberculosis was discovered, the program would be entirely worthwhile.

The association will have a planning meeting shortly, to determine future plans for this program. It is hoped that possibly a similar mass skin-testing program can be conducted for adults in the county.

SKIN-TESTING PROGRAM OUTLINE OF ACTIVITY

1. Decision to have program made by Rock County Tuberculosis Association.
2. Cooperation secured from local organizations and leaders. The following cooperated in the RCTA program.
   a. Rock County Medical Society.
   b. Rock County Health Center.
   c. Rock County Superintendent of Schools.
   d. Pinehurst Sanitorium.
   e. Janesville City Health Department.
3. Committees appointed.
4. Educational program established.
   a. Meetings held with organized groups presenting films, tape recordings, and talks.
   b. Exhibit presented at 4–H Fair.
   c. Informational envelope prepared for each parent.
5. Skin-testing program carried out over 4-week period in the following places.
   a. Rural areas—14 centers established.
   b. Each elementary school in city.
   c. High school.
6. Follow-up of testing carried out.
   a. Results of tests read.
   b. Explanatory letter sent to each student tested giving results.
7. Results tabulated.
   a. Total number tested and participation determined: Rock County—11,438 tested with 381 positive reactions found; 90 per cent participation.

79 Wisconsin MD's Give To Education Fund

Chicago, Jan. 5.—Seventy-nine Wisconsin physicians contributed to the American Medical Education Fund during the last three months of 1954. In addition, the Milwaukee Roentgen Ray Society appropriated a donation to the Fund.

According to a release from the Foundation's headquarters in Chicago, the following doctors have been listed as contributors: Harry Ageloff, Racine; J. E. Albrecht, Jackson; H. W. Bardenwerper, Waterford; A. H. Barr, Port Washington; Antoine Barrette, Peshtigo; K. T. Bauer, West Bend; J. F. Baumgartner, West Bend; J. M. Bell, Marinette; E. L. Bernhardt, West Bend; P. B. Blanchard, Cedarburg; C. H. Boren, Marinette; Clark Boren, Marinette; J. W. Boren, Jr., Marinette; F. I. Bush, West Bend; R. W. Byrne, Milwaukee.

F. J. Cerny, Fond du Lac; Elizabeth Comstock, Arcadia; Irving I. Cowan, Milwaukee; Francis De Salvo, Wausaukee; R. H. Dorr, Belgium; R. H. Driessel and S. J. Driessel, both of West Bend; G. R. Duer, Marinette; R. G. Edwards, Kewaskum; T. D. Elbe, Thiensville; H. C. Evans, Jackson.

R. S. Fisher, Allenton; R. O. Frankow, West Bend; B. H. Glover, Madison; L. H. Graner, Coleman; A. T. Grundahl, West Bend; H. W.

(Continued on page 34)

Name Committee Members for U. S. Congress

Washington, Jan. 27.—Wisconsin Senators Alexander Wiley and Joseph McCarthy will serve on the Senate Judiciary and Government Operations committees respectively, according to the recently released announcement of committee assignments for the 84th Congress.

The Judiciary Committee has jurisdiction over constitutional amendments, including the Bricker amendment, and the Government Operations committee handles reorganization of the Executive branch and investigation of waste and overlapping in federal agencies.

NAME WISCONSIN MEMBERS

Wisconsin members of the House of Representatives, assigned to House committees handling health and medical legislation, include these: Alvin E. O'Konski (R.), Armed Services committee, which handles doctor draft, medical care for military dependents and reserve bills; John W. Brynes (R.), Ways and Means, with jurisdiction over Social Security, taxation and finances; Henry S. Reuss (D.), Government Operations; and Clement J. Zablocki (D.) and Lawrence H. Smith (R.), Foreign Affairs, which considers constitutional amendments.

The Senate Labor and Public Welfare committee has jurisdiction over most health bills, including reinsurance and veterans' hospitalization. Members of this committee are: Democrats—Lister Hill, Ala., chairman; James Murray, Mont.; Matthew Neely, W. Va.; Paul Douglas, Ill.; Herbert Lehman, N. Y.; John Kennedy, Mass.; Pat McNamara, Mich.; Republicans—H. Alexander Smith, N. J.; Irving M. Ives, N. Y.; William Purtell, Conn.; Barry Goldwater, Ariz.; George H. Bender, O.; Gordon Allott, Colo.

HANDLE HEALTH LEGISLATION

Other Senate committees which handle legislation of particular interest to the medical profession are the Armed Forces committee, under the chairmanship of Richard Russell, Ga., which handles military matters including doctor draft, dependent medical care and reserve legislation; Post Office and Civil Service committee, Olin Johnston, S. C., chairman, which has jurisdiction over federal civilian employee legislation, including the contributory health insurance plan; and the Finance committee, Harry F. Byrd, Va., chairman, which handles Social Security, tax bills, and finance matters including veterans' pensions, compensation and insurance.

The Interstate and Foreign Commerce committee will handle most health bills in the House of Representatives including the bulk of the administration program. Its members include the following congressmen. Democrats, J. Percy Priest, Tenn., chairman; Oren Harris, Ark.; Arthur Klein, N. Y.; William Granahan, Pa.; F. Ertel Carlyle, N. C.; John Bell Williams, Miss.; Peter Mack, Jr., Ill.; Kenneth Roberts, Ala.; Morgan Moulder, Mo.; Harley Staggers, W. Va.; Isidore Dollinger, N. Y.; Walter Rogers, Tex.; Martin Dies, Tex.; Samuel Friedel, Md.; John Flynt, Jr., Ga.; Torbert Macdonald, Mass.; Don Hayworth, Mich.

Republicans on the committee are: Charles Wolverton, N. J.; Carl Hinshaw, Calif.; Joseph O'Hara, Minn.; Robert Hale, Me.; James Dolliver, Ia.; John Heselton, Mass.; John Bennett, Mich.; Richard Hoffman, Ill.; John Beamer, Ind.; William Springer, Ill.; Alvin Bush, Pa.; Paul Schenk, O.; Joseph Carrigg, Pa.; Steven Derounian, N. Y.

EDUCATION FUND . . .

(Continued from page 33)

Haasl, Peshtigo; A. H. Heidner, West Bend, J. S. Hess, Jr., Mauston; J. G. Hoffmann and W. C. Hoffmann, both of Hartford; O. W. Hurth, Cedarburg; M. F. Huth, Baraboo; A. J. Jurishica, Milwaukee; H. J. Katz, Cedarburg; C. P. Kauth, Port Washington; P. M. Kauth, West Bend; C. A. Kemper, Chippewa Falls; T. J. Kern, Hartford; C. E. Koepp, Marinette; W. T. Kradwell, Wauwatosa; J. F. Kuzma, Wauwatosa; C. B. Larkin, Madison; F. W. Lehmann, Hartford.

R. J. Maginn, Niagara; J. V. May, Marinette; P. R. McCanna, Marinette; A. J. McCarey, Green Bay; E. A. McCormack, Niagara; D. W. McCormick, Fond du Lac; J. F. McDermott, Green Bay; Ovid O. Meyer, Madison; M. E. Monroe, Hartford; S. A. Morton, Milwaukee; K. J. Moss, Marinette; A. T. Nadeau, Marinette; W. L. Nelson, Wisconsin Rapids; W. A. Nielsen, West Bend.

K. F. Pelant, Grafton; R. B. Pelkey, Pound; J. C. Peterson, Milwaukee; M. G. Peterson, Lake Mills; J. W. Pick, West Bend; K. G. Pinegar, Marinette; Albert Popp, Milwaukee; E. C. Quackenbush, Hartford; V. V. Quandt, Hartford; R. J. Rogers, Oconto; F. W. Sachse, Hartford; S. T. Sandell, Hawthorne; G. F. Savage, Port Washington; W. E. Scheunemann, West Bend; R. C. Schmitz, Madison; J. B. Schrock, Sharon; H. F. Schroeder, Marinette; C. C. Stein, Port Washington.

H. K. Tenney, Madison; Carol Tomlinson, Janesville; Chester Wade, Milwaukee; J. F. Walsh, Port Washington; A. B. Weinstein, Madison; D. H. Witte, Milwaukee; R. A. Wood, Sheboygan; J. D. Zeratsky, Marinette.

What They've Said On Vets' Medical Care

"I have pointed out several times in the past my belief that our first obligation to our veterans is to care for those who have disabilities resulting directly from their service to their country. Financial assistance to veterans with non-service-connected disabilities, on the other hand, should be put as soon as possible on the same basis as financial assistance payable to the non-veterans of our population.

"World War II left us with over 19,000,000 veterans. World events since then mean that hundreds of thousands more will be added each year. At the same time, we have expanded and perfected our social security laws so that they now protect most of our people. The consequences are obvious. Thousands upon thousands of veterans and their families have entitlement to Government payments under both laws. This is confusing, wasteful, and, to many people, hard to understand. . . .

"I strongly urge the Congress to authorize at this session a complete study of our veterans benefits programs and their relationships with our social insurance and other general welfare programs."

—Harry S. Truman, May 23, 1952, message to the House of Representatives.

An Invitation You Will Wish To Accept

The Council on Scientific Work

OF THE

STATE MEDICAL SOCIETY OF WISCONSIN

CORDIALLY INVITES YOU AND YOUR WIFE
TO ATTEND A COMPLETELY NEW AND
EXCITING TYPE OF ANNUAL MEETING

AT

Milwaukee, May 3-4-5, 1955

R.S.V.P.
(After April 1)

See The Following Pages For Details

Something . . .

NEW

NEW DATES: MAY 3–4–5: From this point on, the Annual Meeting will be held in early May to avoid conflicts of hunting, World Series (we have faith in the Braves!), etc.

NEW DAYS: Tuesday through Thursday will coincide with many schedules in which absence from the office is current practice.

and

DIFFERENT!

ONE BASIC PROGRAM: With the exception of the Anesthesia and Ophthalmology and Otolaryngology programs, all meetings will be in one hall, without concurrent scientific programs.

A PRACTICAL APPROACH: The program has been planned especially for the general practitioner, but with specialty emphasis, so as to offer something of value to all members.

NO CONFLICTS WITH MAJOR EVENTS: Members need not be torn between a number of meetings. Golf, the House of Delegates meetings, and other features of the Annual Meeting have been scheduled so as not to interfere with the scientific programs. See page 39 for a schedule of these events.

A NEW TYPE OF ROUND TABLE: The traditional luncheon meetings have been changed, due to difficulties of food service. Cafeteria service in the Auditorium will be provided, and a full schedule of stimulating "study courses" will be held for a full hour between 1:00 and 2:00 p.m. each day. See page 40 for details.

PLAN NOW TO ATTEND THE ANNUAL MEETING ON MAY 3–4–5

Something EXCITING *Every Day . . .*

TUESDAY, MAY 3 . . . . . .

GASTRIC ULCER: Its Diagnosis and Treatment

A symposium with Frederick W. Madison, M. D., John L. Armbruster, M. D., and Forrester Raine, M. D., Milwaukee, as participants and L. J. Van Hecke, M. D., Milwaukee, as moderator

TOPICS FOR GENERAL PROGRAMS:

The Role of Cortisone and Corticotropin in Gastrointestinal Disorders: J. Arnold Bargen, M. D., Mayo Clinic, Rochester, Minnesota

Adenomas and Hemorrhoids: Problems of Rectal Bleeding: Robert Turell, M.D., New York City

The Doctor–Patient Relationship: John Romano, M. D., Rochester, New York (Rogers Memorial Lecture)

Unjustified Gynecological Operations: Richard TeLinde, M. D., Baltimore

Esophageal Hiatus Hernia: Its Fate and Treatment: Ivan Baronofsky, M. D., Minneapolis

The Place of Image Amplifiers and X-ray Movies in Radiology: Earl R. Miller, M.D., San Francisco

SEE PAGE 40 FOR FULL SCHEDULE OF ROUND TABLE STUDY COURSES

WEDNESDAY, MAY 4 . . . . . .

WHAT'S NEW IN MEDICINE:

A full morning of brief, timely reviews of the most recent developments in basic fields of medical practice:

—in surgery: Ivan Baronofsky, M. D., Minneapolis
—in gynecology: Richard TeLinde, M. D., Baltimore
—in pediatrics: Lee Forrest Hill, M. D., Des Moines, Iowa
—in orthopedics: Don H. O'Donoghue, M. D., Oklahoma City
—in drug therapy (omitting hypertension): Ovid O. Meyer, M. D., Madison
—in drug therapy related to hypertension: James A. Evans, M. D., Boston
—in anesthesia: John J. Bonica, M. D., Tacoma, Washington
—in radiology: Earl R. Miller, M. D., San Francisco

PLAN NOW TO ATTEND THE ANNUAL MEETING ON MAY 3–4–5

TOPICS FOR GENERAL PROGRAM IN AFTERNOON:

Endometriosis: Richard TeLinde, M. D., Baltimore

Emergencies in the Newborn Period: Lee Forrest Hill, M. D., Des Moines, Iowa

The Importance of Early Treatment of Injuries to Athletes: Don H. O'Donoghue, M. D., Oklahoma City

Modern Management of the Hypertensive Patient: James A. Evans, M. D., Boston

SPECIAL PROGRAM ON ANESTHESIA: From 2:30 to 4:30 p.m.

With Doctor Bonica as the main speaker discussing "The Proper Role of the Anesthesiologist in the Management of Pain." Complete program in the March issue of the *Journal.*

SEE PAGE 40 FOR FULL SCHEDULE OF ROUND TABLE STUDY COURSES

THURSDAY, MAY 5 . . . . . .

PAIN IN THE NECK:

A special panel discussion by Lester W. Paul, M. D., and Hans H. Reese, M. D., Madison; and Walter P. Blount, M. D., Milwaukee. Samuel S. Sorkin, M. D., Evansville, moderator.

TOPICS FOR GENERAL PROGRAMS:

Present Therapy of Benign and Malignant Breast Conditions: Herbert Lee, M. D., Richmond, Virginia

Rehabilitation of the Patient with Cardiovascular Disease: Joseph G. Benton, M. D., New York City
(The Lucy Ann Droessel Memorial Lecture, Wisconsin Heart Association)

What Does Surgery Offer the Cardiac Patient? Harris B. Shumacker, Jr., M. D., Indianapolis

Shoulder Presentation: William F. Geittmann, M. D., Chicago

Investigation of the Unknown Dead: Charles P. Larson, M. D., Tacoma, Washington

A SPECIAL CLOSING FEATURE OF INTEREST TO ALL PHYSICIANS, NURSES, HOSPITAL ADMINISTRATORS, AND SAFETY ENGINEERS:

Fire and Explosion Hazards in Hospitals, and Their Control: George J. Thomas, M. D., Pittsburgh, Pennsylvania

This will be a dramatic demonstration of great importance to all physicians.

SPECIAL PROGRAM ON OPHTHALMOLOGY AND OTOLARYNGOLOGY:
East Room, Hotel Schroeder

This special meeting will begin with a luncheon, followed by a scientific program, which will be concluded by 4:00 p.m. See March issue of the *Journal* for full details.

Guest speakers: Bruce Fralick, M. D., Ann Arbor, Michigan (ophthalmology) and Ben H. Senturia, M. D., St. Louis (otolaryngology). State speakers: Samuel S. Blankstein, M. D., and Ralph Sproule, M. D., Milwaukee.

PLAN NOW TO ATTEND THE ANNUAL MEETING ON MAY 3-4-5

Special Features

GOLF!

The annual tournament of the Wisconsin Medical Golf Association will be held at the North Hills Country Club on Monday, May 2. Full details as to tee-off time, dinner, and entrance fee can be secured from Mr. Al Luthmers, Medical Society of Milwaukee County, Bankers Building, Milwaukee. You will note this event does not conflict with any portions of the Annual Meeting and should be supported by all M.D.'s who consistently shoot under 150 strokes! The course will be 19 holes, with timing so those weary after 18 holes can improve their scores on the 19th!

HOUSE OF DELEGATES!

To accommodate delegates and officers who wish to attend scientific sessions, the following schedule of meetings has been planned:

Tuesday, May 3: 7:30 p.m.—First Session

Wednesday, May 4: 8:30 a.m.–12:00 noon—Reference Committees
7:30 p.m.—Second Session

Thursday, May 5: 8:30 a.m.—Final Session

AUXILIARY!

The following schedule of business and social events will be followed:

Tuesday, May 3: 6:30 p.m.—Meeting of Board and County Officers

Wednesday, May 4: 9:00 a.m.—Business Session
1:00 p.m.—Luncheon

Thursday, May 5: 9:00 a.m.—Business Session
11:00 a.m.—Post-convention Meeting of Board
1:00 p.m.—Luncheon and Style Show

DINNER AND DANCE!

Following the plan of last year, the closing event will be an informal dinner, followed by professional entertainment and a dance. The formal part of the program will be short, consisting of presentations to new members of the "50 Year Club" and brief statements by the outgoing and incoming presidents.

PLAN NOW TO ATTEND THE ANNUAL MEETING ON MAY 3-4-5

A New Type of

ROUND TABLE DISCUSSION

Because of difficulty in providing food to meet the desires of all members, the traditional luncheon round tables will be replaced by special meetings without food service, as indicated below. All meetings will be held from 1:00 to 2:00 p.m. daily, with cafeteria food available at the Auditorium during the noon hour so there will be no need to leave the building between sessions. A maximum of 75 can be accommodated for each discussion. Members will receive a special announcement about this in the March *Journal*, which will provide a form for registration.

Admission By Ticket Only

NO ADMISSION CHARGE!

Tuesday, May 3:

1. **Regional Enteritis: Its Present-Day Management:** J. Arnold Bargen, M. D., Mayo Clinic (M. C. F. Lindert, M. D., Milwaukee, chairman)
2. **Abuses in Proctology:** Robert Turell, M. D., New York City (Carl W. Eberbach, M. D., Milwaukee, chairman)
3. **Suicide:** John Romano, M. D., Rochester, New York (Joseph A. Kindwall, M. D., Milwaukee, chairman)
4. **The Postphlebitic Syndrome:** James E. Conley, M. D., Milwaukee
5. **Plantar Warts and Calluses:** Donald M. Ruch, M. D., Milwaukee, and Wallace C. Miller, M. D., Racine
6. **Meeting Problems of Hemorrhage in Obstetrics:** Frederick J. Hofmeister, M. D., Milwaukee

Wednesday, May 4:

1. **The Role of Regional Anesthesia in Surgery, Obstetrics, Diagnosis and Therapy:**
   John J. Bonica, M. D., Tacoma, Washington, guest speaker
   Sidney Orth, M. D., Madison, moderator
   Panel Participants: Robert Wylde, M. D., Madison (surgery); George S. Kilkenny, M. D., Milwaukee (obstetrics); and Anthony Tella, M. D., Milwaukee (nonsurgical diseases)
2. **Incontinence of Urine in Women:** Richard TeLinde, M. D., Baltimore (Frederick J. Hofmeister, M. D., Milwaukee, chairman)
3. **Sudden Illnesses in Children:** Lee Forrest Hill, M. D., Des Moines, Iowa (John C. Peterson, M. D., Milwaukee, chairman)
4. **The Place of Radioiodine in Medicine:** Earl R. Miller, M. D., San Francisco (Hans W. Hefke, M. D., Milwaukee, chairman)
5. **The Treatment of Ligament Injuries About the Knee:** Don H. O'Donoghue, M. D., Oklahoma City (Albert C. Schmidt, M. D., Milwaukee, chairman)
6. **Current Concepts in the Treatment of Pulmonary Lesions:** Ivan Baronofsky, M. D., Minneapolis (Joseph W. Gale, M. D., Madison, chairman)
7. **The Choice of Hypertensive Patients for Sympathectomy:** James A. Evans, M. D., Boston (Charles Crumpton, M. D., Madison, chairman)
8. **Newer Drugs and Their Uses:** Ovid O. Meyer, M. D., Madison

Thursday, May 5:

1. **Chronic Relapsing Pancreatitis:** Herbert Lee, M. D., Richmond, Virginia (Kenneth Lemmer, M. D., Madison, chairman)
2. **The Surgical Treatment of Aneurysms and Obstructive Lesions of the Aorta and Peripheral Arteries:** Harris B. Shumacker, Jr., M. D., Indianapolis (Paul F. Hausmann, M. D., Milwaukee, chairman)
3. **Air Embolism:*** Charles P. Larson, M. D., Tacoma, Washington (Dann B. Claudon, M. D., Milwaukee, chairman)
4. **Can Cardiacs Work?** Joseph G. Benton, M.D., New York City (Chairman to be announced)
5. **The Management of Abortion:** William F. Geittmann, M. D., Chicago (Benjamin E. Urdan, M. D., Milwaukee, chairman)
6. **Problems and Advances in the Treatment of Diabetes:** Bruno Peters, M. D., Milwaukee

* Official meeting of Wisconsin Society of Pathologists immediately following close of discussion, at 2:00 p.m.

Round Table Reservations

NO CHARGE, BUT LIMITED ATTENDANCE!

The round tables outlined on this and the previous page are open to all those attending the Annual Meeting *on an advance reservation basis.* Attendance will be limited to 75 persons at each meeting. In the March issue of the *Journal* there will be a reservation slip provided for advance tickets. If the maximum is not reached by the day of the meeting, the remaining tickets can be secured at the registration desk.

Watch The March Journal for Reservation Slip

Roster of Distinguished Guest Speakers

ANNUAL MEETING, MAY 3-4-5

J. ARNOLD BARGEN, M.D.	Professor of Medicine, Mayo Foundation; Chief of Department of Gastroenterology, Mayo Clinic, Rochester, Minnesota
IVAN BARONOFSKY, M.D.	Associate Professor of Surgery, University of Minnesota Medical School, Minneapolis
JOSEPH G. BENTON, M.D.	Coordinator of Education and Research, New York University-Bellevue Medical Center, and Associate Professor of Physical Medicine and Rehabilitation, New York University College of Medicine
JOHN J. BONICA, M.D.	Director, Department of Anesthesiology, Tacoma General Hospital, Tacoma, Washington
JAMES A. EVANS, M.D.	Chief of Vascular Section, Department of Internal Medicine, Lahey Clinic, Boston
BRUCE FRALICK, M.D.	Professor and Chairman, Department of Ophthalmology, University of Michigan Medical School, Ann Arbor, Michigan
WILLIAM F. GEITTMANN, M.D.	Assistant Professor of Obstetrics and Gynecology, Northwestern University Medical School, Chicago
LEE FORREST HILL, M.D.	Des Moines, Iowa
CHARLES P. LARSON, M.D.	Assistant Clinical Professor of Pathology, University of Washington Medical School, Seattle, and Chairman of the Committee on Forensic Pathology, College of American Pathologists
HERBERT LEE, M.D.	Professor of Clinical Surgery, Medical College of Virginia, Richmond
EARL R. MILLER, M.D.	Professor of Radiology, University of California Medical School, San Francisco
DON H. O'DONOGHUE, M.D.	Professor and Chairman, Department of Orthopedic and Fracture Surgery, University of Oklahoma School of Medicine, Oklahoma City
JOHN ROMANO, M.D.	Professor of Psychiatry, University of Rochester School of Medicine, Rochester, New York
BEN H. SENTURIA, M.D.	Associate Professor of Otolaryngology, Washington University School of Medicine, St. Louis, Missouri
HARRIS B. SCHUMACKER, JR., M.D.	Professor and Chairman, Department of Surgery, Indiana University School of Medicine, Indianapolis
RICHARD TE LINDE, M.D.	Professor of Gynecology, Johns Hopkins University School of Medicine, Baltimore
GEORGE J. THOMAS, M.D.	Associate Professor of Surgery and Chairman, Department of Anesthesiology, University of Pittsburgh School of Medicine, Pittsburgh
ROBERT TURELL, M.D.	Assistant Professor of Surgery, in Proctology, Albert Einstein Medical School, New York City

Plan To Attend and Hear These Speakers!

Trempealeau–Jackson–Buffalo

The annual business meeting of the Trempealeau–Jackson–Buffalo County Medical Society was held on November 23, 1954, at the Club Midway, just east of Independence.

Dr. T. J. Rice and *Dr. Russell F. Lewis* of the Marshfield Clinic, Marshfield, spoke to the group on the Maternal Mortality Study conducted by the State Medical Society for Wisconsin for 1953. A report of actions of the House of Delegates at its October 1954 meeting was also presented by the delegates.

The following new officers were elected:

President—*Dr. E. A. Meili*, Cochrane
President-Elect—*Dr. C. B. Moen*, Galesville
Secretary–Treasurer—*Dr. E. P. Rohde*, Galesville
Delegate—*Dr. R. L. MacCornack*, Whitehall
Alternate Delegate—*Dr. B. C. Dockendorff*, Arcadia

Walworth

On November 18, 1954, members of the Walworth County Medical Society entertained their wives at a dinner meeting at Lakelawn Lodge in Delavan. *Dr. S. K. Wynn*, plastic surgeon from Milwaukee, spoke on "Repair of Traumatic Injuries to the Face."

The December meeting was held on December 9, 1954, at the Normandy, Lake Geneva. *Dr. B. I. Brindley*, eye, ear, nose, and throat specialist in Madison, spoke on "Lesions of the Esophagus."

Mr. Robert Towne, Blue Cross–Blue Shield representative, spoke on the special enrollment program for residents of Walworth County. The doctors unanimously endorsed this program.

Election of officers was held, and the following were elected:

President—*Dr. R. A. Moses*, Delavan
Vice-President—*Dr. G. O. Truex*, Darien
Secretary–Treasurer—*Dr. G. A. Smiley*, Delavan
Public Relations Officer—*Dr. John E. Martin, Jr.*, Delavan

On January 15, the society met at the Colonial Hotel at Delavan to hear an address by *Dr. James E. Conley* of Milwaukee. Doctor Conley, who is assistant clinical professor at Marquette University School of Medicine, spoke on "Current Concepts of Peripheral Vascular Diseases."

A grievance committee, consisting of three members and one alternate, was elected by the society.

The Walworth County Medical Auxiliary entertained the society members on January 16. Preprandial refreshments were served at the home of

SACRED HEART SANITARIUM
MILWAUKEE, WISCONSIN

An institution conducted for the diagnosis and treatment of mild nervous disorders and non-infectious diseases; also for rest and recuperation under medical supervision. Equipped with every modern facility for diagnostic purposes. Scientific dietetics, physiomechanotherapy, hydrotherapy, supervised occupational and recreational activities. Literature and rates sent on request.

MEDICAL STAFF
William L. Herner, M. D., Medical Director
J. Frampton Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Earl H. Ninow, M. D.
Paul J. Lawler, M. D.

Dr. and Mrs. *Robert Moses* at Delavan, and a pot-luck dinner followed at the home of *Dr.* and Mrs. *Harold Werbel*, Delavan.

Washington–Ozaukee

At the annual meeting of the Washington–Ozaukee County Medical Society recently held, officers were elected for 1955 as follows:

President—*Dr. M. E. Monroe*, Hartford
Vice-President—*Dr. K. F. Pelant*, Grafton
Secretary–Treasurer—*Dr. J. F. Walsh*, Port Washington
Censor—*Dr. C. P. Kauth*, Port Washington
Delegate—*Dr. E. C. Quackenbush*, Hartford
Alternate Delegate—*Dr. P. B. Blanchard*, Cedarburg

Waukesha

The annual meeting of the Waukesha County Medical Society was held on December 1, 1954, at Haeslaw's Restaurant, Hartland. Officers elected for 1955 are:

President—*Dr. H. A. Gantz*, Waukesha
Vice-President—*Dr. E. C. Van Valin*, Sussex
Secretary–Treasurer—*Dr. F. C. Schoene*, Waukesha
Delegate—*Dr. Martin Werra*, Waukesha
Alternate Delegate—*Dr. William James*, Oconomowoc

The society met at the Merrill Hills Country Club, Waukesha, on January 5, at a dinner meeting attended by the members and their wives.

Guest speaker was Mr. Joseph F. Cairnes, executive vice-president of the Milwaukee Braves Club. Other guests included Mr. Robert Jones, administrator of the Waukesha Memorial Hospital, and Mr. Paul Sodt, administrator of the Oconomowoc Memorial Hospital.

Winnebago

Dr. Sture A. M. Johnson, professor and head of the Department of Dermatology of the University of Wisconsin Medical School and University Hospitals, was the guest speaker at the meeting of the Winnebago County Medical Society on January 6. The meeting was held at the Elks Club, Menasha. Doctor Johnson spoke on "Dermatological Problems."

Ninth Councilor District

Dr. F. R. Keating, Jr., of the Mayo Clinic, Rochester, Minnesota, addressed the members of the Ninth Councilor District at a meeting on November 11 at the Hotel Charles, Marshfield.

Relax the best way
... pause for Coke

Time out for refreshment

DRINK
Coca-Cola
REG. U.S. PAT. OFF.

The doctor presented a paper entitled "Modern Aids to the Physician's Appraisal of Thyroid Functions." About 70 physicians were present.

The Marshfield Clinic physicians were hosts for the gathering.

Wisconsin Academy of General Practice

The sixth annual scientific assembly of the Wisconsin Academy of General Practice was held in Milwaukee from November 29 to December 1, 1954. *Dr. C. F. McDonald* of Milwaukee assumed the office of president, succeeding *Dr. C. G. Reznichek* of Madison.

Dr. R. R. Richards of Eau Claire was named president-elect, and *Dr. Robert F. Purtell*, Milwaukee, was re-elected secretary–treasurer. *Dr. Edward T. Hougen*, Sheboygan, was named speaker of the congress of delegates; and *Dr. Leonard M. Rauen* of Kenosha was elected vice-speaker.

Other new officers are *Drs. J. J. Leahy*, Park Falls; *J. S. Devitt*, Milwaukee; *Marshall Boudry*, Waupaca; *S. S. Sorkin*, Evansville; *M. V. Overman*, Neillsville; *David Goldstein*, Kenosha; *T. J. Nereim*, Madison; and *Jerome Fons*, Milwaukee, directors. Doctors Reznichek and Devitt were elected delegates to the American Academy of General Practice.

Speakers at the scientific assembly included *Dr. O. S. Orth*, professor of anesthesiology at the University of Wisconsin Medical School; *Dr. Peter B. Golden* and *Dr. Thomas V. Geppert*, Madison; *Dr. C. F. Broderick*, Wisconsin Dells; and *Dr. F. J. Hofmeister*, Milwaukee.

Meetings were held at the Hotel Schroeder, the Blatz Auditorium, and the Wisconsin Club.

County Chapters of Academy of General Practice Meet

At a meeting of the Fond du Lac Chapter of the Wisconsin Academy of General Practice at the Elks Club, Fond du Lac, December 8, 1954, the following officers were elected for the coming year:

President—*Dr. C. P. Reslock*, Waupun

Vice-President—*Dr. John C. McCullough*, Fond du Lac

Secretary—*Dr. R. L. Waffle*, Fond du Lac

Officers elected by the Racine–Kenosha Chapter recently are:

President—*Dr. James J. Lutz*, Kenosha

Vice-President—*Dr. William Madden*, Racine

Secretary–Treasurer—*Dr. Morris Siegel*, Kenosha

Delegates—*Dr. Joseph Postorino*, Racine; *Dr. A. M. Rauch*, Kenosha; and *Dr. C. M. Creswell*, Kenosha

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The Rock County Chapter, meeting on December 8, 1954, at the Corral, in Beloit, elected the following officers:

President—*Dr. T. L. Vogel*, Milton Junction
President-Elect—*Dr. M. J. Donkle*, Janesville
Secretary-Treasurer—*Dr. Esther Rau*, Janesville

At this meeting *Dr. D. W. Pranke*, Beloit, spoke on "Office Urology."

Milwaukee Academy of Medicine

Dr. Paul R. Patterson, professor of pediatrics at Albany Medical College, Albany, New York, was the guest speaker at the scientific meeting of the Milwaukee Academy of Medicine on December 21, 1954, at Columbia Hospital Staff Auditorium. He spoke on "Mucoviscidosis in Children and Adults." A special clinic on pancreatic disease was held in the morning.

The annual dinner meeting of the Academy was held on January 18 at the University Club, Milwaukee. *Dr. E. R. Daniels*, Milwaukee, was elected president-elect. *Dr. J. F. Kuzma*, professor and head of the Department of Pathology at the Marquette University School of Medicine, became president; and *Dr. Maurice Hardgrove* was elected vice-president.

Others elected were *Dr. James E. Conley*, secretary; *Dr. Morrison Schroeder*, treasurer; *Dr. Howard J. Lee*, librarian; *Dr. Francis F. Rosenbaum*, curator of the Brown library; and *Dr. M. C. F. Lindert*, chairman of the membership committee.

Newly elected members of the Council of the Academy are *Drs. Harry Beckman, John D. Charles, Albert G. Martin, Arthur A. Holbrook, David W. Ovitt*, and *George C. Owen. Dr. Frederick W. Madison* and Harold S. Falk were re-elected to the Board of Trustees for three-year terms.

Milwaukee Neuro-Psychiatric Society

The Milwaukee Neuro-Psychiatric Society held its regular meeting at the University Club, Milwaukee, on January 19.

Dr. Reginald G. Bickford, electroencephalographer at the Mayo Clinic, Rochester, Minnesota, spoke on "Some Clinical and Research Applications of Depth Electrography of the Human Brain." His talk was illustrated by a sound movie and slides.

Milwaukee Oto-Ophthalmic Society

On January 25, the Milwaukee Oto-Ophthalmic Society met at the University Club, Milwaukee. Papers were presented by *Dr. Roger Lehman* of the Department of Otolaryngology of the Veterans Hospital, Wood; Dr. Richard Fogel, Wood; and *Dr. Arvid Holm*, pathologist in the Department of Ophthalmology, Marquette University School of Medicine.

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News Items and Personals

Doctor Livingstone Moves Office

Dr. J. W. Livingstone of Hudson has moved his office to his residence at 503 Locust Street. The building vacated by him, according to historians, has been used as a doctor's office for 95 years. In 1861 the late Dr. Otis Hoyt opened his office there. Later it was used by Dr. Charles King, a son-in-law of Doctor Hoyt. At various times dentists have used the building; and since 1920, Doctor Livingstone had been located there.

Dr. Harry Caskey Now at Clintonville

Dr. Harry Caskey, who has spent the last two years in the U. S. Air Force, has joined *Dr. William G. Arnold* in the Clintonville Clinic. He is replacing *Dr. Robert Bolinske,* who left for service with the Air Force last October.

Kenosha Hospital Elects Staff Officers

Dr. A. M. Rauch was elected president of the Kenosha Hospital medical staff at a recent meeting. Other officers elected are *Dr. George Schulte,* vice-president; *Dr. Leonard M. Rauen,* secretary; and *Dr. Charles Pechous,* member of the board of directors.

New Officers Elected at St. Agnes Hospital, Fond du Lac

Dr. E. H. Pawsat, Fond du Lac pediatrician, was elected chief of staff of St. Agnes Hospital recently, succeeding *Dr. J. S. Wier. Dr. Harvey Sharpe, Jr.* was re-elected for a second term as staff secretary.

Dr. F. J. Pfeifer, New London, Feted

Members of the Rotary Club of New London honored *Dr. F. J. Pfeifer* for his 45 years of service to the community when they opened their November 15 meeting. A short ceremony was held and a special toast given in recognition of the occasion.

On November 18 Doctor Pfeifer was guest of honor at a dinner and program presented by the registered nurses of New London and the surrounding area and the staff doctors and sisters of the New London Community Hospital.

Doctor Pfeifer was graduated from the Wisconsin College of Physicians and Surgeons, Milwaukee, in 1909, and then began his practice at New London. He also served for 30 years as public health officer of the community.

Dr. C. W. Giesen Honored for 50 Years' Service

Dr. Charles W. Giesen of Superior was honored on December 22 by the Douglas County Medical Society and sisters of St. Mary's Hospital on the completion of 50 years of practice in Superior.

The dinner meeting was held at St. Mary's Hospital. The Reverend Father Charles Haefner, hospital chaplain, spoke on behalf of the sisters; and a plaque recognizing his 50 years of service was presented to Doctor Giesen by *Dr. J. W. McGill.*

Doctor Giesen is a member of the 50 Year Club of the State Medical Society. He was born in Iowa in 1879 and was graduated from the University of Illinois College of Medicine in 1904. He then began his practice in Superior, specializing in dermatology.

Doctor Giesen has served as president and secretary of the Douglas County Medical Society. He is a member of the American Academy of Dermatology.

Wabeno Physician Medical Advisor to Legion Committee

Dr. George H. Reddick, Wabeno, has been appointed medical advisor to the Department Rehabilitation Committee of the American Legion.

Officers Elected at Sheboygan Memorial Hospital

At a monthly luncheon meeting of the medical staff of the Sheboygan Memorial Hospital on December 21, *Dr. H. J. Hansen* of Sheboygan Falls was elected president of the staff. *Dr. L. M. Simonson* was elected vice-president; *Dr. Jane Moir* and *Dr. Edward T. Hougen* were elected members of the executive committee; and *Dr. Fred A. Nause* will continue as secretary of the staff. All of these physicians are located in Sheboygan.

Dr. J. V. May Honored by Profession

Dr. J. V. May of Marinette was honored by the medical profession at a testimonial dinner at the Riverside Country Club, Menominee, Michigan, on November 17.

Members of the Marinette–Florence County Medical Society, in cooperation with the Menominee County Society and the auxiliaries of both organizations, recognized Doctor May's 50 years of service in the medical profession on this occasion. Doctor May, an eye, ear, nose, and throat specialist, was born in Russell, Iowa, in 1876; was graduated from St. Louis College of Physicians and Surgeons in 1900; and took postgraduate work at Illinois Medical College and in London, England, and Vienna, Austria. He practiced in Wautoma and Granite before moving to Marinette in 1908.

His career was depicted in the form of a book entitled, "This is Your Life, Dr. May"; and *Dr. Kenneth Moss*, president of the county medical society presented him with a plaque from the Marinette–Florence County Society. Other tributes were paid by *Dr. H. F. Schroeder;* the Rev. Axel Pearson of the Presbyterian Church; *Dr. G. R. Duer; Dr. Arthur J. McCarey*, president of the State Medical Society, Green Bay; Mr. Charles Crownhart, secretary, and Mr. Robert Murphy, legal counsel, of the State Medical Society.

Mr. Norman Johnson of the Marinette Rotary Club presented Doctor May with one of the four Red Rose certificates awarded by the club in the past 12 years. The certificate is given in recognition of extraordinary service to the community.

Dr. Sherman Lee Attends Postgraduate Course in Chicago

During the week of November 14 , 1954, *Dr. Sherman R. Lee* of Menomonie attended a postgraduate course in general surgery sponsored by the Chicago Medical Society. At the end of the week Doctor Lee attended a meeting of the State Society's Subcommittee on Limited Licensees in Milwaukee.

Doctor Housner Attends Lectures in Minneapolis

Dr. R. E. Housner of Richland Center attended lectures at the University of Minnesota, Minneapolis, during the week of November 21. The lectures were on orthopedic surgery.

Former Racine Physician Is Fellow in Neurology

Dr. Niels L. Low, formerly of Racine, has finished a year as research associate in epilepsy and clinical electroencephalography at the University of Illinois. He is now a Fellow in pediatric neurology at Columbia University, Presbyterian Hospital Center in New York City.

Staff Officers Elected at Marshfield Hospital

At the annual meeting of the medical staff of St. Joseph's Hospital, Marshfield, on January 12, *Dr. W. A. Olson* of Greenwood was elected chief of staff. *Dr. James S. Vedder*, Marshfield, was elected secretary, and *Dr. Charles A. Vedder*, Marshfield, vice-chief of staff.

Elected to the hospital executive committee were Doctor Olson and *Drs. G. S. Custer, James Vedder, R. H. Wink, and R. F. Lewis*, all of Marshfield.

Dr. Charles Vedder was named chief of surgery; and *Dr. R. L. Hansen*, Colby, was appointed chief of the general practice section. *Dr. Karl H. Doege*, Marshfield, remains as chief of medicine.

Doctor Keller Establishes Practice in South Dakota

Dr. L. W. Keller, who practiced at Brillion for four years before entering military service in September 1952, has now received his honorable discharge and has established a practice at Webster, South Dakota. He is on the staff of the Peabody Clinic.

Bloomington Physician at Prairie du Chien

Dr. William Cusick, who had maintained a full-time practice at Bloomington, has become associated with the Beaumont Clinic at Prairie du Chien. He will continue to maintain office hours at Bloomington on Tuesday, Thursday, and Saturday mornings and on Wednesday evenings.

Doctor Cusick is replacing *Dr. Verne Epley*, who left Prairie du Chien recently to enter military service.

Doctor Hartzell Returns to Grantsburg

Dr. Richard L. Hartzell, who has been in military service for nearly two years, has returned to Grants-

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burg and is now associated with *Dr. Harry H. Larson.* Doctor Hartzell served with the U. S. Air Force at the Mountain Home Air Force Base near Boise, Idaho.

Tomah Physician Opens New Office Building

Dr. J. S. Mubarak of Tomah has opened a new clinic building, which will be staffed by Doctor Mubarak and *Dr. G. A. Landmann.* The building, which is located in the 100 block of West Milwaukee Street, Tomah, was built by Doctor Mubarak and is expected to house two more doctors in the future.

Doctor Sroka Attends Internal Medicine Course

Dr. W. C. Sroka, Burlington, attended a postgraduate course in internal medicine in Chicago during the week of November 14. The course was sponsored by the Chicago Medical Society.

Hospital Staff Officers Elected at Marinette

Dr. Kenneth Moss of Marinette was elected president of the St. Joseph–Lloyd Hospital staff at a luncheon meeting of the staff on December 9 at Marinette. Other officers elected are Dr. William S. Jones, Jr., of Menominee, Michigan, president-elect; and *Dr. Clark Boren,* Marinette, secretary and treasurer.

Doctor Tverberg in Germany

Dr. M. S. Tverberg, former Mauston physician, is now with the Army Medical Corps and is stationed at Leipheim in southern Germany. He is assigned to the 54th Combat Engineer Battalion dispensary and may be addressed as Captain M. S. Tverberg, Medical Detachment, 54th Engineer Battalion, APO 35, New York, New York.

Doctor Lucas in Postgraduate Work

Dr. P. M. Lucas, who practiced at Monticello for the last year and a half, is now at Wood Veterans Hospital, where he is specializing in orthopedic surgery. His residency began on January 1, 1955.

Paul F. Doege Medical Center Opens

Dr. Paul F. Doege of Marshfield recently opened his newly constructed doctors' office building in that city. Associated with him is Dr. Robert D. Taylor, formerly of Cleveland, Ohio.

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Dr. B. C. Prentice to Do Advanced Study

Dr. B. C. Prentice, who had maintained an office in Ashland on Monday and Thursday afternoons, has left for a year's advanced study on urology and surgery at St. Mary's Hospital, Minneapolis. His father, *Dr. J. W. Prentice*, will maintain the office on Wednesday and Saturday mornings.

Doctor Albrecht Is Washington County Coroner

Dr. James E. Albrecht of Jackson has been appointed coroner of Washington County by Governor Walter Kohler. Formerly elected to the office in 1952, he decided against running in 1954. His successor has moved out of the county, and Doctor Albrecht is now filling the vacancy which existed in the office.

Dr. R. A. Flynn in Surgery Fellowship

On February 1, *Dr. R. A. Flynn* of Sparta began a year's fellowship in advanced surgery at the Miller Hospital and University of Minnesota, St. Paul. He returned from two years' military service last July and has been associated with the Sparta Clinic since April 1947.

Doctor Cook Serves as X-ray Consultant

La Crosse physician, *Dr. Arnold A. Cook*, serves as x-ray consultant to staff members of the Krohn Clinic, Black River Falls, as well as for the Grandview and La Crosse Hospitals at La Crosse. He is also consultant for Iowa hospitals in Cresco, Waukon, and Decorah.

Doctor Weisse Attends Obstetrics and Gynecology Meet

Dr. H. A. Weisse of Plymouth attended the sixth American Congress on Obstetrics and Gynecology at the Palmer House, Chicago, from December 13 to 17, 1954. The Congress was sponsored jointly by the American Committee on Maternal Welfare and the American Academy of Obstetrics and Gynecology and was attended by physicians and nurses from all over the free world.

Doctor Parrish Opens His Own Office

Dr. John G. Parrish, who had been associated with *Dr. H. S. Fuson* in Eau Claire for a year and a half, has opened his own office for general practice at 2131 Fenwick Avenue, Eau Claire. Doctor Parrish graduated from Temple University Medical School in Philadelphia in 1952. He has served as house physician at Luther Hospital, Eau Claire.

Doctor Evenson in General Practice at Cedarburg

In the November issue of the *Journal* it was reported that *Dr. Roland Evenson* had associated with *Dr. Henry J. Katz* at Cedarburg following a residency in eye, ear, nose, and throat at Marshfield. Doctor Evenson has advised that he had taken a year and a half of training at the Marshfield Clinic on a preceptor basis rather than as a formal residency. Therefore, he is engaged in general practice at Cedarburg.

College of Surgeons Inducts Fellows

Drs. J. R. Erickson and *F. W. Reichardt* of Stevens Point and *Dr. L. E. Fazen, Jr.*, of Racine were inducted as fellows of the American College of Surgeons at its November 19 meeting. The meeting was held at Atlantic City, New Jersey.

Physicians Visit Eli Lilly and Company

More than 50 physicians and pharmacists from Jefferson, Waukesha, Washington, and Ozaukee counties visited the Eli Lilly and Company laboratories at Indianapolis during the week of January 16. Those making the trip also visited the Lilly Clinic at the Indianapolis General Hospital.

THIRD AND TWELFTH DISTRICTS NEWS

Portage Hospital Elects Staff Officers

At a meeting of the medical staff of Divine Savior Hospital, Portage, in December, *Dr. J. W. Macgregor* of Portage was elected chief of staff. In addition, the following Portage physicians were re-elected: *Dr. Edward Tierney*, vice-president, and *Dr. Thomas Henney*, secretary–treasurer. Those elected to the executive committee are *Dr. C. W. Henney*, Portage; *Dr. J. H. Houghton*, Wisconsin Dells; and *Dr. R. F. Inman*, Montello.

St. Mary's Hospital, Madison, Elects Officers

Dr. Samuel S. Sorkin, Evansville, was elected president of the St. Mary's Hospital Association, Madison, on January 18 when the medical staff held a banquet and business meeting. Other Madison officers elected were *Dr. R. F. Collins*, vice-president, and *Dr. George Benish*, secretary–treasurer. *Dr. Robin Allin* was elected representative to serve on the Dane County Medical Society's Board of Trustees.

Doctor Poser Observes 60th Year of Practice

On the first of January, *Dr. Edward M. Poser* of Columbus observed his sixtieth year as a physician.

Doctor Poser was graduated from Rush Medical College, Chicago, in 1893 and established his practice in Columbus in 1894 following a year at the Milwaukee County Hospital.

Three of his sons are physicians; two of them, Drs. John and Rolf, practice with him, and the other, Dr. Edward S., is located in Chicago. A fourth son, Frederick, is an attorney at Hagerstown, Maryland.

In 1950, the Chamber of Commerce presented Doctor Poser with a bronze plaque in honor of his fifty-fifth year of service to Columbus.

Dr. Horace K. Tenney III, Receives Fellowship

Dr. Horace K. Tenney, III, of Madison was one of 182 pediatricians who received fellowships from the American Academy of Pediatrics on November 19. Fellowships in the Academy are granted by election to physicians who have specialized for five years in child and infant care and who pass a comprehensive examination.

Doctor Tenney spoke at a meeting of the Dane County Medical Assistants on November 23. His subject was "The Kiddie Camp and its Activities."

Mercy Hospital, Janesville, Elects Officers

At the annual meeting of the Mercy Hospital staff on December 9, the following Janesville physicians were elected as staff officers: *Dr. T. J. Snodgrass*, chief of staff; *Dr. M. J. Donkle*, president; *Dr. E. R. Otterholt*, vice-president; *Dr. Eugene Betlach*, secretary; and *Drs. E. W. Reinardy, Jack Schroeder*, and *J. R. Schroder*, board members.

Dr. O. O. Meyer Speaks in Canada

Speaking on "Early Diagnosis and Treatment of Coma," and "Arthritis," *Dr. O. O. Meyer* presented two papers at a district medical meeting in Calgary, Alberta, Canada, on January 21. Doctor Meyer is chairman of the Department of Medicine at the University of Wisconsin Medical School.

Physicians, Civic and Farm Leaders Meet

At a luncheon meeting of physicians, civic and farm leaders on January 13 at the Simon House, Madison, Dr. W. Paul Holbrook of Tucson, Arizona, addressed the group on arthritis.

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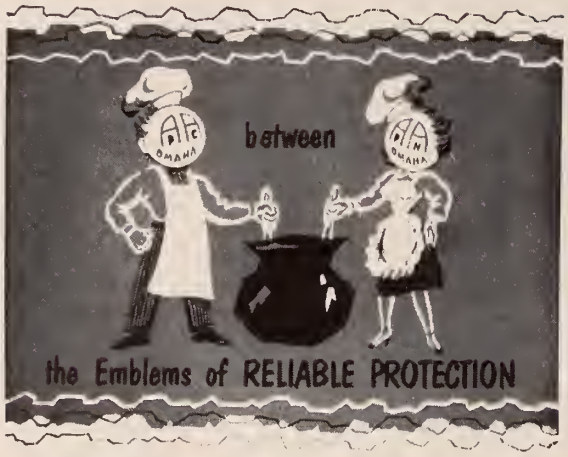

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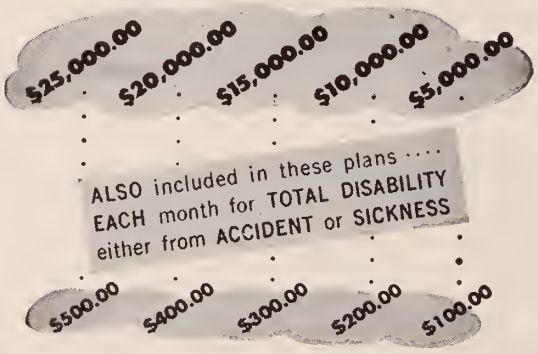

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Doctor Campbell President-Elect of Obstetrics Academy

Dr. R. E. Campbell, professor of obstetrics and gynecology at the University of Wisconsin Medical School, was named president-elect of the American Academy of Obstetrics and Gynecology on December 14, 1954. He will take office in December 1955.

Officers Elected at Madison General Hospital

When the staff of the Madison General Hospital met on December 28, *Dr. C. O. Vingom* was re-elected chief of staff. Other Madison physicians re-elected were *Dr. Homer M. Carter*, vice-chief of staff; *Dr. E. J. Nordby*, secretary-treasurer; *Dr. T. J. Nereim*, chief of the general practice section; and *Dr. Alexander M. Iams*, chief of the pediatric section.

Other physicians elected were *Dr. S. B. Harper*, chief of the surgical section; *Dr. William V. Luetke*, chief of the obstetrical and gynecological section; and *Dr. Robert M. Becker*, chief of the medical section.

University of Wisconsin Holds Preceptor Program

On November 19 and 20, 1954, the University of Wisconsin held its annual fall preceptor program. This program marked the thirtieth anniversary of the opening of the State of Wisconsin General Hospital and the establishment of a four-year medical school program at Wisconsin.

The ceremonies included presentation of an oil painting of Dr. Robin Carl Buerki, first superintendent of the hospital, to the University of Wisconsin. The presentation was made by *Dr. Harold M. Coon*, superintendent of University Hospitals; and the portrait was accepted by Mr. Oscar Rennebohm, vice-president of the Board of Regents of the University of Wisconsin and former governor of Wisconsin.

Doctor Buerki, who is at present superintendent of Henry Ford Hospital, Detroit, Michigan, was present and gave a short talk on his observations concerning the preceptor system in Wisconsin.

Doctor Parkin Speaks at Rio

On November 22, *Dr. R. C. Parkin*, coordinator of graduate medical education at the University of Wisconsin, spoke to the Women's Club of Rio. His topic was "Preventive Medicine."

Postgraduate Course in Anesthesiology at Wisconsin

Dr. O. Sidney Orth, assisted by the staff of the Department of Anesthesiology at the University of Wisconsin Medical School, presented a postgraduate course entitled "Anesthesiology for the General Practitioner," on January 25, 26, and 27. The course was sponsored by the medical school.

Dr. Thomas Allin Leaves Plain

Dr. Thomas Allin, who had practiced at Plain since June 1953, moved to Cincinnati, Ohio, in December 1954. He has joined the medical research department of the William S. Merrell Company of Cincinnati.

Doctor Tibbitts Appointed Coroner in Sauk County

Dr. James A. Tibbitts, who recently began his practice at Reedsburg, has been appointed coroner of Sauk County. The appointment made by Governor Walter J. Kohler fills the vacancy caused by the resignation of *Dr. Thomas Allin.*

Doctor Maxwell Elected Chief of Staff at Milwaukee Hospital

Dr. John W. Maxwell, Sr. was elected chief of staff of St. Anthony's Hospital in Milwaukee when the staff held its elections recently.

Dr. John Gonce Gives Address at Berlin

Dr. John E. Gonce, Jr., professor of pediatrics at the University of Wisconsin Medical School, spoke to the staff of the Berlin Memorial Hospital on November 11. His subject was "Abnormal Pulmonary Ventilation and Its Treatment."

University Doctors Attend Surgical Meeting

Dr. Erwin R. Schmidt, professor of surgery at the University of Wisconsin Medical School, attended the annual meeting of the Western Surgical Association held at Colorado Springs, Colorado, from December 1 to 4. Other Madison physicians attending were *Dr. Anthony R. Curreri* and *Dr. Joseph W. Gale.*

Marquette Holds Postgraduate Forum

A postgraduate forum on management of trauma was held at the Marquette University School of Medicine on December 11, 1954. General practitioners, surgeons, and industrial physicians attended.

Doctor Peterman Speaks in Houston, Texas

Dr. M. G. Peterman, Milwaukee, lectured at the University of Texas Children's Hospital in Houston on December 4, 1954. Doctor Peterman's specialty is pediatrics.

Milwaukee Physician Appointed Ecuadorian Consul

Dr. Joseph M. Regan, Wauwatosa orthopedic surgeon, has been appointed consul for the Ecuadorian government. His duties include protecting the rights of Ecuadorian citizens visiting or living in Milwaukee and developing commerce between Milwaukee and Ecuador. His consulate duties are not such that they will interfere with his work as a surgeon.

Marquette Students Visit Eli Lilly

Members of the senior and junior classes of the Marquette University School of Medicine visited Eli Lilly and Company, Indianapolis, Indiana, on December 19 to 21.

Doctor Peters Elected Staff Secretary

Dr. Leo M. Peters of Milwaukee was elected secretary–treasurer of the Deaconess Hospital medical staff on December 7.

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Dr. John Hirschboeck Appointed to Hospital Council

Dr. John S. Hirschboeck, Marquette University School of Medicine dean, has been appointed to a one-year term on the Federal Hospital Council of the U. S. Department of Health, Education, and Welfare. He will represent the medical profession on the Council provided by the Hill-Burton Hospital Construction Act to determine policy and rules for the administration of the act.

Dr. J. P. Wild Elected to Plastic Surgery Society

Dr. J. P. Wild, Milwaukee, has been elected to the American Otorhinologic Society for Plastic Surgery, Inc. He has been specializing in eye, ear, nose, and throat.

Doctor Grindrod Locates at Oregon

Dr. J. M. Grindrod is now in the practice of medicine and surgery at Oregon, Wisconsin. He is a graduate of the University of Wisconsin Medical School and has formerly practiced at Peshtigo and Oconomowoc.

MARRIAGES

Dr. Charles C. Davin, Kenosha, to Miss Margaret McWilliams, Kenosha, November 20.

SOCIETY RECORDS

New Members

G. A. Dedinsky,* Box 73, Smock, Pennsylvania.

John Hogan, Twin Lakes.

W. C. Rattan, 520 58th Street, Kenosha.

L. H. Edelblute, Bellin Memorial Hospital, Green Bay.

R. C. Olson, 130 East Walnut Street, Green Bay.

H. A. L. Hartmann, 426 North Charter Street, Madison.

G. W. Beebe,* 1515 Drummond, Eau Claire.

V. T. Davis, 2001 Van Hise Avenue, Madison.

Herbert Giller, 208 East Wisconsin Avenue, Milwaukee.

T. S. Kemp, 110 East Main Street, Madison.

D. J. Noll, 1300 University Avenue, Madison.

Ruth A. Stoerker, 1300 University Avenue, Madison.

Paul L. Eisele,* Veterans Administration Hospital, Waukesha.

Roger A. Kjentvet, Wild Rose.

J. A. Seidl, 323 South Central Avenue, Richland Center.

James A. Tibbitts, 114 South Park Street, Reedsburg.

O. E. Toenhart,* 2946 North Second Street, Milwaukee.

M. A. Warpinski, 1066 Mather, Green Bay.

A. M. Ford,* Roberts.

D. C. Atwood,* Apartment 4, 37 Sherman Terrace, Madison.

W. A. Stoops, Liberty Powder Defense Corporation, Baraboo.

Antoine Barrette, 132 North Emery Street, Peshtigo.

Changes of Address

Shimpei Sakaguchi,** Milwaukee, to 104 Dogwood Road, Oceanside, California.

O. C. Clark, Milwaukee, to 326 Windsor Drive, Waukesha.

T. G. Allin, Jr., Plain, to 8611 Plainfield Road, Cincinnati, Ohio.

J. W. Brown, Madison, to 411 30th Street, Oakland 9, California.

E. R. Hodgson, Madison, to P. O. Box 520, Walla Walla, Washington.

W. M. Pfeifer, Walpole, Massachusetts, to 5945 North Bay Ridge Avenue, Milwaukee.

E. E. Skroch,** Great Lakes, Illinois, to U.S.S. Haven (AH12), % Fleet Post Office, San Francisco, California.

J. H. Sage, Riverside, California, to 863 Palm Canyon Drive, Palm Springs, California.

David A. Freed, Elkhorn, to P. O. Box 125, West Union, Iowa.

H. S. Caskey, % Postmaster, New York, to % M. L. Schriefer, Box 13, Athens.

J. F. Koppa, Milwaukee, to 4006 Green Avenue, Madison 4.

R. M. Quetsch,** San Francisco, California, to Medical Company, 10th Inf. Reg., 5th Inf. Division, APO 112, New York, New York.

W. P. Deiss, Jr., Madison, to Duke University, V. A. Hospital, Durham, North Carolina.

L. L. Keppler, Jr., Milwaukee, to 5500 Ridge Road, Parma, Ohio.

N. L. Low, Chicago, Illinois, to 710 West 168th Street, New York, New York.

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H. N. Lubing,** Madison, to U.S.N.T.C., Inf. 172, Great Lakes, Illinois.

J. E. Nilles,** % Postmaster, San Francisco, to 5012th S.U., U.S.A. Infirmary, Fort Sheridan, Illinois.

H. L. Burdick,** Milton, to 3510th U.S.A.F. Hospital, Randolph Air Force Base, Texas.

R. S. Overton,** Janesville, to 3906 Kidd Drive, Honolulu, T. H.

** Military Service.

DEATHS

Dr. Eugene R. Hering, retired Shell Lake physician, died on October 3, 1954, at the age of 77 years.

Born on October 2, 1877, Doctor Hering was graduated from Rush Medical College, Chicago, in 1899. He practiced at Shell Lake until his retirement in 1942.

He is survived by a son, Captain E. R. Hering, Jr., a surgeon in the U. S. Navy.

Doctor Hering was a former member of the Barron–Washburn–Sawyer–Burnett County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Dr. Walter F. Gager, 60 years of age, died at his home in Rhinelander on November 16, 1954, following an illness of several months.

He was born on March 1, 1894, in Oconto, and was graduated from the University of Wisconsin Medical School in 1934. He interned at Milwaukee Hospital in 1934–1935 and then had a year's residency at the same hospital.

Doctor Gager was a member of the Oneida–Vilas County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He had served as secretary of the county society in the past.

Survivors include his widow, Pauline; a son, Walter E., a hospital corpsman in the U. S. Navy, stationed at the Green Bay Naval Reserve Training Center; and his mother, Mrs. Flora Gager.

Dr. Chadwick Connell Newman, Wausau physician, died on November 18, 1954, as the result of injuries sustained in an automobile accident. He was 28 years of age.

Born on August 2, 1926, in Janesville, Doctor Newman was graduated from the University of Wisconsin Medical School in 1952 and interned at St. Lawrence Hospital, Lansing, Michigan, the following year. He had been in military service with the U. S. Army from November 1944 to August 1946.

Following his internship, Doctor Newman practiced at the Wittenberg Clinic at Wittenberg and in June 1954 moved to Wausau, where he associated with the Stahmer Clinic.

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Doctor Newman was a member of the Shawano County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his parents, Mr. and Mrs. C. G. Newman of East Lansing, Michigan, and a sister, Virginia, East Lansing.

Dr. Thomas J. Buckley, North Freedom, passed away at a Baraboo hospital on November 20, 1954, at the age of 83 years.

Doctor Buckley was born on January 10, 1871, in Chicago and received his medical degree from the University of Illinois College of Medicine in 1894. He had served as health officer of Sauk County and had practiced at Fayette, Briggsville, and Coloma prior to moving to North Freedom, where he was located for 17 years. He retired from active practice in 1951.

He was a former member of the Sauk County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors are his widow; one son, Leo, of Des Plaines, Illinois; two daughters, Mrs. Genevieve Griffin and Miss Faye Buckley, both of Chicago; a brother, George, of Elmhurst, Illinois; two sisters, Mrs. Fay Maars of Phoenix, Arizona, and Miss Ella Buckley, Elmhurst, Illinois.

Dr. John Allen Enright, Milwaukee, passed away at a Milwaukee hospital on November 20, 1954, at the age of 49 years.

Doctor Enright was born on August 17, 1905, at West Bend and graduated from Marquette University School of Medicine in 1932. He interned at St. Mary's Hospital, Milwaukee, and had a 15-month residency at Johnston Emergency Hospital, Milwaukee, completing it in October 1933. He served as a captain in the Army Air Force in World War II, seeing 16 months' service prior to February 1945.

He was president of the medical staff of St. Mary's Hospital, Milwaukee, in 1953 and had also served as a member of the Executive Council of that hospital. He had been a member of the Cancer Committee, the Grievance Committee, the Public Relations Committee, the Surgical Care Operating Committee, and the Medical Business Service Committee of the Medical Society of Milwaukee County and had served as the county society's delegate to the House of Delegates of the State Medical Society. He was a member of the Committee on Public Policy of the State Medical Society.

Doctor Enright was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. He acted as president of the Milwaukee Chapter of the American Academy of General Practice in 1953.

Surviving Doctor Enright are his widow, Cecilia; two daughters, Carol and Barbara; and a son, John A. Enright, II, all at home; three brothers, Melvin E. and Gerald J., Milwaukee, and Arthur W., Madison; and a sister, Mrs. Carol M. Fischer, Milwaukee.

Dr. William Joseph Hanley, 63 years of age, died at a Milwaukee hospital on November 23 following an illness of several months.

Doctor Hanley was born July 10, 1891, and was graduated in 1914 from Marquette University School of Medicine. He interned at Milwaukee County Hospital in 1915 and at the Chicago Lying-In Hospital in 1916.

After World War I, he practiced medicine at Kenosha before returning to Milwaukee in 1932. He was a resident physician at Milwaukee County Emergency Hospital during the last 16 years.

Doctor Hanley was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include three brothers, Cornelius P. and George M., both of Milwaukee, and Thomas E. of Marathon, Florida. A sister, Mrs. Katherine Dunham, Milwaukee, also survives.

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Dr. Fred William Riehl, Milwaukee physician and the oldest licensed pharmacist in the city, died at his home on December 6, 1954, at the age of 84 years.

He was born on February 12, 1870, and was graduated from Milwaukee Medical College in 1903. Early in his career he operated a drug store, having been licensed as a pharmacist in 1891.

With Dr. William Malone, Doctor Riehl founded the old Hanover Hospital on the site of the present St. Luke's Hospital.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Barbara, with whom he celebrated their sixtieth wedding anniversary in June 1954.

Dr. John Steele Barnes, former Milwaukee physician, died on December 8, 1954, at Albuquerque, New Mexico, where he had lived for the last two years. He was 87 years of age.

Born on March 16, 1867, at Oxford, Connecticut, Doctor Barnes was graduated from Yale University School of Medicine in 1891 and interned at Bridgeport Hospital, Bridgeport, Connecticut.

He was a Diplomate of the American Board of Ophthalmology and specialized in eye, ear, nose, and throat work until his retirement several years ago. He was a member of the Fifty Year Club of the State Medical Society and held membership in the Medical Society of Milwaukee County, a life membership in the State Medical Society of Wisconsin, and membership in the American Medical Association.

Doctor Barnes is survived by a daughter, Mrs. Alfred M. Granum of Albuquerque, New Mexico.

Dr. Alexander Schlapik, former Kenosha physician, passed away on December 11, 1954, at a Miami Beach, Florida, hospital. Doctor Schlapik, who had recently retired from his practice in Kenosha, was 70 years of age.

Born in Chicago on November 30, 1884, Doctor Schlapik attended Northwestern University Medical School, Chicago, from which he received his medical degree in 1906. He also studied in Vienna, Austria, and served an internship at Mercy Hospital, Chicago. Prior to practicing in Kenosha, he had been located at Iron River, Michigan, and Milwaukee, Wisconsin.

In recent years Doctor Schlapik specialized in dermatology and urology. He was a member of the American Urological Society, the North Central Urological Society, and the Wisconsin State Urological Society.

He was a member of the Kenosha County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He had served as president of the Kenosha County Society in 1930.

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Survivors include his widow, Carol; two brothers, Dr. Daniel, Miami Beach, and Joseph of Chicago; and three sisters, Mrs. Ann Stone and Mrs. Rolla Goodman, Chicago, and Mrs. Mollie Aronson, Miami.

Dr. Frank A. Everhard, retired Ripon physician, passed away January 9 at the age of 90 years.

He was born on March 6, 1864, and was graduated from Rush Medical College, Chicago, in 1887. He practiced at Ripon from 1887 to 1920, when he retired. His father preceded him in the medical profession.

Doctor Everhard is survived by one son, Fred, of Chicago and three grandchildren.

RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Madison, October 14 to 16, 1954.

Name	*School of Graduation*	*Year*	*Address*
Allen, Richard Herbert	Harvard Medical School	1950	509 S. Third St., Janesville
Aronson, Abraham	University of Illinois	1935	Mendota State Hospital, Madison
Cromer, Robert Warren	Northwestern University	1952	824½ Fifth Ave., Antigo
Erchul, James William	University of Minnesota	1948	St. Clare Hospital, Monroe
Ewald, Donald George	Loyola University	1952	Milwaukee County General Hospital, Milwaukee
Fais, Oswill Green	State University of Iowa	1945	6210 West Greenfield Ave., West Allis
Fogle, Richard Johnston	Ohio State University	1949	2624 N. 72nd St., Wauwatosa
Gibson, Richard Davis	Northwestern University	1951	Ripon
Hansell, Robert Joseph	Ohio State University	1932	Room 428, 104 Main St., Oshkosh
High, Anne Lufkin	University of Michigan	1939	1048 E. Lexington Blvd., Milwaukee
Kemp, Thomas Schreiner	University of Minnesota	1948	110 E. Main St., Madison
Kirn, George John	Harvard Medical School	1951	1836 South Ave., La Crosse
Klein, Ernest Sol	University of Illinois	1937	750 S. State St., Elgin, Ill.
Lin, Paul Min.	Temple University	1954	707 S. Fourth St., Camden, N. J.
Loescher, Thomas M.	University of Colorado	1949	120 S. Oneida, Appleton
McCarthy, Mor James	Georgetown University	1947	Hillsboro
McHale, Josiah Anderson	Harvard Medical School	1948	523 Main St., Racine
Middleton, William D.	University of Illinois	1914	901 Clarence Ct., Madison
Puckett, Robert Walter	University of Iowa	1947	921 16th Ave., Monroe
Roberts, Helen Bronislava	University of Edinburgh	1949	907 Sixth Ave., S. W., Rochester, Minn.
Schaefer, Joseph Charles	University of Wisconsin	1950	Michigan State Sanatorium, Howell, Mich.
Schneck, Jack Irving	Baylor University	1937	935 Rosemary St., Waukesha
Schwiebinger, Gerald W.	University of Wisconsin	1948	1300 University Ave., Madison
Stenborg, Walter Patrick	University of Illinois	1944	208 E. Wisconsin Ave., Milwaukee
Taylor, Robert Dewey	Northwestern University	1940	2020 E. 93rd, Cleveland, Ohio
Wells, Arthur Herman	Harvard Medical School	1930	St. Luke's Hospital, Duluth, Minn.

The following physicians were granted licenses by examination by the State Board of Medical Examiners at a meeting in Madison, October 14 to 16, 1954.

Name	*School of Graduation*	*Year*	*Address*
Hommel, Placido Ramos Vasquez	University of Illinois	1916	128 N. Main, Elkader, Ia.
Lindquist, Frederick Max	Marquette University	1953	1421 17th St., Two Rivers
Lourdeaux, Stanley Jos.	Duke University	1940	2364 S. 81st St., West Allis
Pepper, Brian Wilfrid	University of Manitoba	1953	1821 W. Wisconsin Ave., Milwaukee
Supan, Peter Callistus	St. Louis University	1923	841 Rose Drive, Ann Arbor, Mich.
Weisbrod, Louis Wm.	University of Wisconsin	1953	Monroe Clinic, Monroe
Wheeler, Clarence Jos., Jr.	Johns Hopkins University	1950	1300 University Ave., Madison

MILWAUKEE GYNECOLOGICAL SOCIETY

There will be a meeting of the Milwaukee Gynecological Society on Monday, March 28, at the Wisconsin Club at 8:00 p.m.

Speaker for the meeting is Andrew A. Marchetti, M. D., professor of obstetrics and gynecology, Georgetown University Medical School, Washington, D. C. His topic title is "Vesico–Urethral Suspension—a Ten-Year Survey."

Facts about

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Looking for "live" program material for a county medical society meeting or a hospital staff meeting? The Commission on Prepaid Plans, in cooperation with the Wisconsin Chapter of the Health Insurance Council, is offering the speaking services of a team of staff members to discuss health insurance problems. The team includes a staff member of the State Medical Society and a representative of a Wisconsin private insurance carrier. They will discuss the fundamentals of health insurance protection, uniform claim blanks, payment for completing claim forms, use and abuse of health insurance, major illness coverage, deductibles, and many other aspects of health protection.

If your county society desires this health insurance team to present a program at any meeting, please write giving time, place, and date. Contact the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin.

Northeastern Wisconsin and Upper Peninsula

Physicians in northeastern Wisconsin will be interested in the fact that the employees of Pickands–Mather Company of Hurley and a number of mining companies in the Upper Peninsula of Michigan have their health insurance protection with Physicians Indemnity Plan of Wisconsin, operated by the State Medical Society. The plan selected by the mining company employees provides *surgical coverage only.* It is an indemnity type program with a $200 maximum schedule of benefits. The plan has been in effect since November 1, 1954. The program is part of the health protection plan negotiated within the steel industry as a whole.

Deductible Program

Another milestone in Wisconsin Physicians Service development is marked by the installation of the first "deductible" surgical–medical program for Blue Shield of Wisconsin. Approximately 150 employees of the Dairyland Power Cooperative, with headquarters in La Crosse and employees in several other locations, now have a $25 deductible program of coverage under the regular group WPS contract. The deductible applies to all benefits covered by the contract —surgery, in-hospital medical care, maternity, anesthesia, and x-ray.

To preserve the "full payment" feature of Wisconsin Blue Shield, all participating physicians will receive the full amount of their fees established by the fee schedule for particular services. If an employee or dependent goes to a physician not participating in the plan, the full amount of the fee will be made payable to the employee. Dairyland Power Cooperative will reimburse WPS for the deductible amount of each claim paid on behalf of its employees.

Walworth County

A new attempt at low-cost enrollment for Blue Shield and Blue Cross was made in Walworth County during January. Enrollment booths were set up at central locations in Whitewater, Delavan, Elkhorn, and Burlington on consecutive days. Three newspaper ads in the weeklies of each town, a letter to every employer in the county, and literature dispensers in hospitals and doctors' offices spread the word of the enrollment opportunity. Several hundred applications were received; and although it is too early to determine how many were accepted, it is apparent that the first effort at low-cost enrollment may offer as much potential as more expensive promotional programs for non-group coverage.

For Information or Advice

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The Journal Bookshelf

Members of the Society may obtain loan packets on any medical topic they wish to study.

All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal "Bookshelf,"* are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry, and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

The Meaning of Social Medicine. By Iago Galdston, M. D., Secretary, Medical Information Bureau, The New York Academy of Medicine. Cambridge, Massachusetts, Published for the Commonwealth Fund by Harvard University Press, 1954. Price $2.75.

In this volume Doctor Galdston records and evaluates some of the investigations and activities which he undertook during five years as Secretary to the Committee on Medicine and the Changing Order of the New York Academy of Medicine. He gives his own concept of social medicine and explains the basis for his belief that it constitutes an appropriate framework for more effective medical education and practice.

Doctor Galdston traces the origin, growth, and historical significance of social medicine, finding great divergence of opinion concerning the meaning of the term itself. He takes issue with definitions which are static and based on distinguishing techniques rather than underlying philosophy and clearly differentiates between social medicine and programs which are currently termed "socialized medicine." In fact, he sees the two as opposed to each other in that socialized medicine is concerned with the distribution of medical services as they are currently practiced while social medicine constitutes a desirable reform within medicine itself and emerges from past medical history and growing medical concern with the preservation of health rather than merely the treatment of disease. Credit is given to the great contributions of public health, preventive medicine, and curative medicine; but the author also points out their limitations, calling attention to the current problem of chronic illness, the conversion of mortality into morbidity. Many individuals "appear to have gained years of welcome life but these may too often prove to be years of painful travail, years of dependency, unproductive years which in the last analysis are social and individual liabilities rather than assets."

To bring about a change in medical focus, Doctor Galdston recommends modification of subject matter content and teaching methods in medical schools. With emphasis placed on "life and its fulfillment" rather than "death and disease," he discusses ways in which educational content might be reoriented and the physician trained for a larger role than that which he describes as "middleman between the patient and the diagnostic laboratories." He sees social medicine as absorbing and integrating, with its fundamentals "some of the major data and perspectives of psychiatry, notably the dynamics of goal determined behavior, and the respective roles which biology, as well as the immediate and remote environments of the individual, play in setting goals and affecting their attainment." Such social medicine "is and should be the logical, i.e., the bio-sociological issue of what has been and is happening in medicine and society"—the desirable resolution of the multiplex problems which beset society and medicine.

In the addendum the author discusses the history and present status of social medicine in England, again making a clear distinction between this and the National Health Service although he sees both as growing out of England's long concern for the individual and his welfare.

Whether or not one agrees with Doctor Galdston's conclusions and recommendations, this volume should be a valuable contribution to the limited writing in this field. It serves to give perspective to some of the current problems and issues concerned with the distribution of medical care. It envisions a quality of medical practice which is increasingly desired by the public and which physicians should become competent to give. The author brings us up to date in this complex concept of medicine and points toward goals and methods which have yet to be tested.—S. G.

The Medical Clinics of North America. Nationwide Number. Philadelphia, W. B. Saunders Company, 1953.

Under the title "Symposium on Bedside Management," there are assembled in this issue of the Medical Clinics essays reviewing available therapeu-

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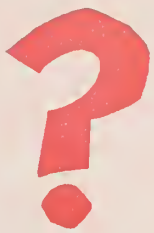

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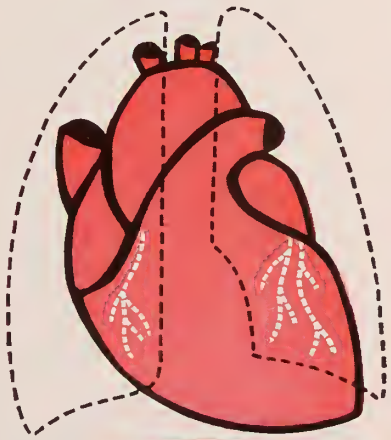

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tic resources in some 20 widely varied areas. The authors are, for the most part, widely known for their contributions in the field of their discussion and have prepared excellent critical summaries. A few have been rather perfunctory in their approach, and in one or two instances emphasis has been rather heavily placed in the direction of the writer's own theories.

The chapters on the management of cardiac emergencies and on the treatment of cardiac decompensation, with especial reference to resistant cases, evaluate a number of "tricks of the trade" and are particularly worth reading by the general practitioner and internist.

A chapter on the management of diabetes, while necessarily quite brief and limited in its scope, outlines a rational and thoughtful approach in line with modern knowledge of the disease which is well worth the consideration of anyone who must deal with this disease.—J. L. S.

ARE YOU USING THESE GUIDES?

The divisions, committees, and councils of the State Medical Society of Wisconsin, in cooperation with various voluntary and governmental agencies, have been responsible for the development of numerous guides and manuals related to certain aspects of medical practice. While these have been made available to every member, it is quite possible they may not be at hand when the occasion arises for their use.

The following guides and manuals are available upon request to the State Medical Society office:

1. **Adoption Procedures in Wisconsin**—A reminder of statutes governing adoption proceedings and a guide to agencies serving the unwed mother or married parents seeking to place a child for adoption.
2. **Civil Defense Manual for Mobile Medical Team Personnel**—An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.
3. **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.
4. **Ethical Practices in Reference to Workmen's Compensation and the "Open Panel Program"**—A guide for the use of physicians, industrial nurses, management and insurance carriers in handling consultation, reports, complaints, and free choice of physician in relation to the compensation program.
5. **Guide for the Development of a Local or Regional Rheumatic Fever Program**—Recommendations for a model plan of rheumatic fever program emphasizing the convalescent home, diagnostic and follow-up clinics, and a home-service program.
6. **Hearing Conservation Programs for Wisconsin Industries**—Some recommended standards and principles for providing a hearing conservation program in industry.
7. **Industrial Health, A Guide for Medical and Nursing Personnel**—General principles and suggested procedures for an industrial health program, especially in relation to standing orders for nurses.
8. **Medical Care of Migrant Agricultural Workers**—A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.
9. **Membership Manual of the State Medical Society of Wisconsin**—A manual on membership and dues problems of the State Medical Society and the American Medical Association. Primarily for the assistance of county medical society officers.
10. **Minimum Standards of Medical Care for County Hospitals**—A guide to physicians and county asylum superintendents concerning medical care for patients in county hospitals.
11. **Participation by Physicians in Radio and Television Programs**—A guide to physicians and county medical societies for their presentation of or participation in radio and television programs.
12. **Planning Your Career as a Medical Associate**—A brochure to acquaint young people with the careers open to them in fields related to medicine.
13. **School Health Examinations**—A guide for physicians and school authorities in establishing a program of school health examinations.
14. **School Vision Screening Program**—An outline to facilitate the development of a program to detect significant visual defects among school children.
15. **Standards for Management Services Desiring to Advertise in the Wisconsin Medical Journal**—A list of standards under which the Wisconsin Medical Journal will accept advertising on behalf of management services for physicians.
16. **Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers**—A list of the objectives of the State Medical Society in devising the Wisconsin Plan and the conditions under which insurance carriers may participate in that plan.
17. **Wisconsin Physicians Service Manual**—A guide for physicians and their office assistants in servicing contracts held by subscribers to the Blue Shield Plan of the State Medical Society of Wisconsin.
18. **Wisconsin Veterans Medical Service Agency Schedule of Fees**—A description of the Wisconsin Veterans Medical Service Agency of the State Medical Society, instructions on arranging "home-town" care for veterans with service-connected disabilities, and the schedule of fees negotiated with the Veterans Administration.

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CORRESPONDENCE

Re: Sufficiency of Consent of One Parent for Operation on Minor

Question

You have addressed the following inquiry to the state offices of this Society: "Is the consent of one parent to surgery on a minor sufficient in Wisconsin without seeking the consent of the other?"

You have explained that the parents of a minor who is a patient of yours have been separated for some time, but that no legal proceedings have been brought which affect the status of the marriage, and that no action has been taken by any court with reference to custody of this minor. The latter has remained exclusively in his mother's custody since the informal separation of the parents. The mother is willing to give such consent, but it is doubtful whether the father would do so.

Because the question you have raised is of general interest to the profession, we have been asked by the Society to render you this opinion.

Answer

It is a general rule of law that in a state in which both parents have equal custody of a minor, and in which no court has modified such custody, the consent of one parent is sufficient authorization for surgery needed by such child. Wisconsin is among the states which follow the rule of equal custodial rights of parents in a minor child in the absence of judicial action modifying such rights. We therefore conclude that in this particular case, assuming the facts to be as stated above, and assuming that the operation is being performed in this state, it is sufficient legal protection for you to obtain a consent to surgery on the minor signed by the mother without joining the father in such consent.

Should you have any further questions in this matter, do not hesitate to raise them.

Sincerely yours,

Counsel

Co-operative Extension Work in Agriculture and Home Economics

State of Wisconsin

Mr. Earl Thayer
State Medical Society
704 East Gorham Street
Madison, Wisconsin
Dear Mr. Thayer:

On behalf of the county 4-H members, I would like to thank your organization for the recognition they gave to the outstanding Health club in our county during the past year.

It has always been my feeling that not enough effort has been made in 4-H work toward improving the health of our members, and the awards which you present are a great help in interesting our 4-H members in striving to plan better health programs.

Sincerely yours,
Elwood Hoffman
County Club Agent

Frequently the Society receives helpful comments from radio stations which carry "The March of Medicine" program under the direction of Dr. Robert C. Parkin, coordinator of postgraduate education. Several of the most constructive suggestions have been made by Mr. Bob Dick, program director of Radio Station WIBA in Madison. Recently the Society received the following memo from him:

To: State Medical Society Re: Effort to be Helpful

Couple of random thoughts on *The March of Medicine* production (which, incidentally, we find the best of all our syndicated tapes or discs!):

(1) I think you'd save time, paper and money by cutting down on the "cue" material, and putting just the closing line on the format sheet . . .

(2) We always try to conceal the fact that programs are "canned." We work "transcribed" as unobtrusively as possible. I think that something like the close we are suggesting would please other stations as well and conform to all the rules.

With your fine script writing and editing, and Mike's and Doctor Parkin's easy manner, *The March of Medicine* is a mighty interesting show.

Waubeka, Wisconsin

State Medical Society of Wisconsin
Madison, Wisconsin

Gentlemen:

In the name of the Waubeka 4-H Club I want to thank you for the year's subscription to "Today's Health" magazine. We have found the magazine is very interesting and helpful. The copies were passed out to the various leaders last year. This year the club members decided to have monthly topic reviews by volunteer members. In this way we feel all members will derive benefit, even the youngest members.

Thank you again.

Sincerely yours,
Mrs. Joseph Hames, Sr.
Club Leader

THE WISCONSIN MEDICAL JOURNAL

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Volume 54 MARCH 1955 Number 3

Hypofibrinogenemia Associated with Abruptio Placentae

By WILLIAM L. SEMLER, M. D., DAVID J. WERNER, M. D., JEROME J. WERNER, M. D., DEMETRIOS C. TRIANTAPHYLLOPOULOS, M. D., ALVIN M. KURZON, M. D., and TIBOR J. GREENWALT, M. D.

Milwaukee

THE occurrence of an unusual bleeding tendency associated with premature separation of the placenta was noted by De Lee[1] in 1901. Dieckmann,[2] in 1936, was the first to demonstrate that hypofibrinogenemia was responsible for the coagulation defect in some cases of abruptio placentae. The hemorrhagic phenomena which may complicate amniotic fluid embolism have also been attributed to low fibrinogen levels.[3] Reid *et al.*[4] reported that retention of a dead fetus *in utero* for a prolonged period could lead to a similar syndrome. Extensive literature is accumulating concerning the various aspects of this fascinating problem. This paper is not intended to be a review of the literature. Rather, our purpose is to focus the attention of Wisconsin physicians on a catastrophic hemorrhagic complication of pregnancy which is readily diagnosable and easily managed if it is kept in mind.

The pathogenesis of the disturbance of the coagulation mechanism under discussion is not completely established. Schneider[5] introduced the concept that the low fibrinogen levels are caused by *in vivo* defibrination of the maternal blood stream as a result of the sudden escape of thromboplastin-rich material into the circulation. The placenta has a high content of thromboplastin which can be extracted into the fluid of a retroplacental hematoma. The forceful contractions of labor may cause rupture of the hematoma through the decidual plate into the marginal sinus. At term the placenta has 200 units of thromboplastin per gram of tissue, whereas the human brain has only 50 units per gram of tissue.[6] Amniotic fluid contains approximately one unit of thromboplastin per gram but may carry larger quantities into the circulation with it during the process of embolization. Some observers feel that the activation of fibrinolytic enzymes explains the low fibrinogen levels.[7] Indeed, increased fibrinolytic activity is frequently found in the sera of these patients. The inactive precursor of fibrinolysin (plasminogen), normally present in plasma, is readily activated under many circumstances; for example, in hemorrhagic shock, mental stress, and anxiety states and following the injection of Adrenalin.[8] It is difficult to determine if the presence of fibrinolysin is a secondary manifestation or of etiologic significance.

Diagnosis

The diagnosis is easily established. Simplicity and speed in verifying the clinical evidence are important for the proper management of the patient. It is not important to know the exact level of fibrinogen. Proper specimens may be collected for detailed analysis in the laboratory after the pressure of the emergency is over.

The "clot observation test" is recommended by the authors.[9] The test consists of placing freshly drawn blood into a clean, dry test tube and observing the nature of the clot. Failure of the blood to clot or to form a stable clot is evidence that the plasma fibrinogen has dropped to a critical level. If a clot forms but dissolves within an hour when incubated at 37 C., there is the probability that fibrinolysis is present in addition to fibrinogenopenia.

Case Reports

Case 1—Mrs. E. R., a 31-year-old, white female, gravida II, para I, with an expected date of confinement of March 18, 1954, was admitted on December 20, 1953, complaining of lower abdominal cramps and intermittent vaginal bleeding of four weeks' duration. She had been hospitalized for study and observation one week earlier. At that time bleeding, clotting, and prothrombin times were normal. Toxemia of pregnancy was not present.

Ten hours after admission and after 1 hour, 52 minutes of active labor, the patient spontaneously delivered the entire uterine contents intact followed by approximately 300 cc. of blood and clots. A small infant was removed alive from its amniotic sac and placed in an air lock but died after 24 hours. The placenta had many old clots on its surface.

Profuse vaginal bleeding continued in spite of oxytocics and uterine massage. A sample of blood drawn 30 minutes after delivery failed to clot. Bleeding from the gums, epistaxis, and a hematemesis were noted one hour postpartum. Two and one-half hours postpartum, three pints of blood had been administered and a blood specimen still failed to clot. After 1,800 mg. of Fraction I (fibrinogen) and a fourth pint of blood were infused, the patient's blood clotted. This patient was never in shock and was dismissed on the fifth postpartum day after an uneventful course.

* * *

Case 2—Mrs. H. H., a 37-year-old, white female, gravida IV, para III, with an expected date of confinement of February 26, 1954, was admitted on January 1, 1954, with acute, continuous abdominal pain. She had a history of hypertension and albuminuria prior to gestation. Physical examination revealed the uterus to be hard and tender. Amniotomy was performed, and a live male infant weighing 4.5 pounds was delivered spontaneously after three hours of labor. A large clot was present on the placental surface.

The fundus remained firm and contracted, but continuous oozing from the uterus, episiotomy and venipuncture sites was noted. A specimen of blood drawn at this time failed to form an adequate clot. The hemorrhagic manifestations continued, and the patient was in mild shock in spite of the administration of 5 per cent glucose, 500 cc. of dextran, and two pints of bank blood, whereupon 2,100 mg. of Fraction I was administered. A blood sample drawn after the infusion of the fibrinogen formed a good clot. The patient made an uneventful recovery but required the transfusion of five additional pints of bank blood to raise the red blood cell count and hemoglobin to acceptable levels.

* * *

Case 3—Mrs. V. B., a 38-year-old, white female, gravida VI, para V, with an expected date of confinement of April 29, 1954, was admitted to the hospital at 8:30 p.m. on March 17, 1954, because of sudden onset of vaginal bleeding and severe abdominal pain shortly prior to admission. She was dyspneic and pale, and her abdomen was rigid and very tender. The blood pressure and pulse were not obtainable. Her shock responded to the administration of 500 cc. of liquid plasma and 2,000 cc. of glucose in saline. Blood specimens drawn at 9:00 p.m. failed to clot. She was given three pints of bank blood during the next four hours, and 2,100 mg. of Fraction I was administered at 10:30 p.m. A blood specimen now formed a firm, stable clot. A three-pound stillbirth was delivered by cesarean section at 11:30 p.m. The placenta was found to be completely detached, and the uterus was filled with dark, liquid blood and clots. Considerable oozing was encountered during the surgery. The patient required a total of seven pints of blood before leaving the hospital. She has had an uncomplicated convalescence. This patient had preeclamptic toxemia during this and her preceding pregnancies.

* * *

Case 4—Mrs. L. J. was a 22-year-old colored female with preeclamptic toxemia diagnosed earlier in pregnancy. Continuous abdominal pain developed on the morning of the day of admission to the hospital. There was no external bleeding prior to entry. The patient was in the thirtieth week of pregnancy. Her uterus was hard and tender and extended three fingerbreadths above the umbilicus. The fetal parts could not be identified. Her blood pressure was 160/110. Bleeding from the gums developed, and a blood specimen drawn at 8:00 p.m. failed to clot. At 9:42 p.m., a stillbirth was delivered spontaneously. There was considerable hemorrhage with ensuing mild shock. Three

pints of bank blood were transfused. By 11:20 p.m. the hemorrhage had ceased. A large placental infarct, 7 cm. in diameter, was present. The patient's subsequent stay in the hospital was uneventful.

Management

The method of management is tempered by the status of the clotting mechanism. Hypofibrinogenemia must be promptly corrected or delivery by either the pelvic or the abdominal route may be attended by disaster. The choice of obstetrical treatment depends on the degree of placental separation, the status of the infant, and on whether or not shock is present. Artificial rupture of the membranes may be performed in the mild cases to initiate labor, and it simultaneously serves to control uterine bleeding and to deter further placental separation. If cesarean section becomes necessary, a clot observation test must be performed prior to surgery to be sure of the adequacy of the clotting mechanism.

In the severe cases the fetus is usually dead, and all efforts are directed to saving the mother. The patient is given multiple transfusions to combat shock. When there is evidence of hypofibrinogenemia, the use of Fraction I of Cohn, which contains mainly fibrinogen and antihemophilic globulin, has to be considered. The danger of transmitting homologous serum hepatitis with this preparation should be borne in mind. None of our patients received more than 2.1 Gm. of this material, but in severe cases 8 or more Gm. may be needed. Our fourth case responded adequately to the transfusion of three pints of bank blood; therefore fibrinogen was not used. When the patient has recovered sufficiently from shock and the clotting mechanism is deemed to be adequate, then one must decide whether to deliver the patient normally or to do a cesarean section. It is important to take a positive course of action promptly, for the advantage gained by transfusions and the administration of Fraction I (fibrinogen) may be short-lived.

TABLE 1—*Summary of Cases*

Time	Therapy	Fibrinogen* (mg. per cent)
Case 1—E. R., delivered 5:52 p.m., December 20, 1953—Expected Date of Confinement, March 18, 1954		
6:20 p.m.		144.4**
8:15 p.m.	3 pints bank blood	278.3
9:00 p.m.	1 pint bank blood 1,800 mg. Fraction I	315.6
December 21, 1953 9:15 a.m.		433.3
Case 2—H. H., delivered 2:50 a.m., January 1, 1954—Expected Date of Confinement, February 26, 1954		
2:50 a.m.	5 per cent glucose, 500 cc. dextran 2 pints bank blood	96.3**
7:00-7:45 a.m.	2,100 mg. Fraction I	187.3
January 4, 1954	3 pints bank blood	428.0
Case 3—V. B., delivered (cesarean) 11:30 p.m., March 17, 1954—Expected Date of Confinement, April 29, 1954		
	500 cc. liquid plasma .5 pints bank blood	192.6
10:30 p.m.	2,100 mg. Fraction I	
March 18, 1954	4.5 pints bank blood	
March 19, 1954	2 pints bank blood	
Case 4—L. J., delivered 9:42 p.m., March 30, 1954, at 30 weeks of gestation		
10:00 p.m.	.5 pints bank blood 2.5 pints bank blood	165.0

*In this laboratory, the mean fibrinogen level of 25 patients studied during the last trimester of pregnancy has been found to be 503 mg. per cent (range, 294 to 685).

**No fibrin clot formed. Determination performed on centrifuged sediment.

The clot observation test should be repeated at regular intervals. Additional blood transfusions and adequate amounts of fibrinogen must be administered if there is any indication of failure of maintenance of the clotting mechanism.

Summary

The hemorrhagic complications of pregnancy associated with low plasma fibrinogen levels have been briefly discussed. Four cases of abruptio placentae in which hemorrhage was associated with hypofibrinogenemia have been presented. The diagnosis of this condition can be readily made by the "clot observation test." The obstetrical management of abruptio placentae is briefly presented, and the use of blood transfusions and Fraction I of Cohn (fibrinogen) in correcting hypofibrinogenemia is discussed.

The authors are grateful to Dr. Edgar End for permission to include a case report of one of his patients.

The fibrinogen used in this study was supplied by Dr. Sam T. Gibson, Associate Director, Blood Program, The American National Red Cross, National Headquarters, Washington 13, D. C.

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Scientific Program

WISCONSIN CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

May 1, 1955

Hotel Schroeder, Milwaukee

12:00 Noon
Business Luncheon, Parlor A, 4th Floor
Scientific Program, East Room, 5th Floor

1. "Clinical Aspects of Pleurisy With Effusion"
   Jay A. Myers, M. D., Minneapolis, Minnesota
2. "The Prognosis of Bronchiectasis"
   A. M. Olsen, M. D., Rochester, Minnesota
3. "The Appraisal of the Routine Treatment of Bronchial Asthma"
   George L. Waldbott, M. D., Detroit, Michigan
4. "Rheumatic Heart Disease is Preventable"
   Chester M. Kurtz, M. D., Madison, Wisconsin
5. "Therapeutic Implications of Pulmonary Function Studies"
   H. A. Andrews, Jr., M. D., Chicago, Illinois
6. "Advantages Derived From Routine Chest X-Ray Examination In A General Hospital"
   Abraham Melamed, M. D., Milwaukee, Wisconsin

Extensive Hemangiomas Treated By Radium*

A Report of Two Cases Followed for Six and Thirteen Years Respectively

By E. A. POHLE, M. D., Ph. D.,** and DAVID C. IVIE, M. D.***
Madison

Fig. 1a

Fig. 1b

Fig. 1c

Introduction

OUR experience in the treatment of hemangiomas has been related in previous publications. It includes our method of handling infected hemangiomas with radium,[1] a survey of 146 consecutive noninfected hemangiomas treated with radium,[2] and a case of an extensive hemangioma involving the right forearm and wrist treated successfully with roentgen rays.[3] Children in whom a satisfactory cosmetic result has been achieved are seldom brought back to allow a long-range follow-up. Since the question of late injury after radiation therapy of these lesions is often brought up, we feel that it is worth while to present the history of two babies with extensive lesions whose cases were followed for 6 and 13 years respectively.

Case Reports

Case 1.—(X-ray No. 8935). A white male, 8 weeks old, was first examined in the Department of Radiology at the State of Wisconsin General Hospital on November 21, 1939. The child had been delivered at term without difficulty. Present at birth was an extensive hemangioma of the left cheek, left upper lip and left side of the nose, with some involvement of the upper palate and a small necrotic area in the left nasolabial fold. Superiorly, the lesion extended to the left lower eyelid (Fig. 1a).

Between November 21, 1939, and December 27, 1940, the patient was treated eight times, with only a part of the lesion being treated at one time. A 10 milligram radium plaque and radon screens were employed in the treatments. With the former, doses of 1.7 to 3.33 mgh were delivered at a one-millimeter distance; and with the latter, doses of 100 to 150 mch were given at a one-centimeter distance with a 0.5 mm Ag and 1.0 mm Br filtration. In all, a total of 8.8 mgh of radium and 520 mch of radon was given.

By April 1941, all angiomatous tissue had disappeared; and only slight swelling of the left upper lip and fine telangiectasia over the left cheek were noted. Figure 1b shows the appearance of the lesion on July 23, 1941; and Figure 1c shows the final cosmetic result on July 3, 1945.

---

* Presented at the One Hundred and Thirteenth Annual Meeting of the State Medical Society of Wisconsin, October 5, 1954.

** Professor of Radiology, University of Wisconsin Medical School.

*** Resident Physician, University of Wisconsin Medical School.

Fig. 2a

Fig. 2b

Fig. 2c

Fig. 3

Case 2.—(X-ray No. 7650). A 10-month-old girl was first examined in the Department of Radiology at the State of Wisconsin General Hospital on July 27, 1938. The child was delivered by forceps, at which time she sustained an injury over the upper left eyelid. Because of this injury she had a monocular convergence, iris adhesions, and a left globe slightly smaller than the right. In addition, she had a cavernous hemangioma of the left upper eyelid at birth; and at our first examination this measured 1½ x 2 x 1 cm. The hemangioma extended deep into the lid and gave the palpebral conjunctiva a deep purplish color. The weight of the lid made it impossible for the child to hold the eye open (Fig. 2a).

Between July 1938 and October 1939 the patient was treated 12 times, with an average interval of 4 to 6 weeks between treatments. The lesion was divided into various areas, with treatment given to each area as indicated. A 10 milligram radium plaque and radon screens were employed in the treatment. With the radium plaque at 1/10-centimeter distance, doses of 2.5 to 7.5 mgh were given during a single treatment. A maximum of six radon screens was used at one time with filtration of 0.5 mm Ag and 1.0 mm Br and at distances varying from 1 to 2 centimeters. The total dosage from the screens varied from 66 to 100 mch but usually was 100 mch.

Figure 2b shows the result as of January 11, 1940, and Figure 2c as of November 25, 1942. An eye consultant examined the child first in December 1938 and for the third time in December 1942, when he noted the cosmetic result and could determine no change in the eye itself. The patient was lost to follow-up after a November 1942 visit until October 1951, when she returned for examination. Figure 3 shows the result about 13 years after the initial treatment.

Comment

We believe that these two cases show that, even in extensive lesions, good cosmetic results can be achieved and that late injuries can be avoided. Occasionally the statement has been made that these birthmarks disappear spontaneously by the age of three years. Recently, van der Werf[4] reported a series of 47 children with hemangiomas of various types. He observed complete regression in most after several years. He believes, therefore, that "treatment is as a rule unnecessary. The author feels that it should be discouraged, since the cosmetic results are often unsatisfactory. The scars are large, the skin is thin, and irregular pigmentation remains."

Our experience does not agree with his observation; surely any lesion which is definitely increasing in size should be treated. We are in complete agreement here with Pfahler,[5] who has had many years of experience in this field. He states, "Hemangioma is a disfiguring and distressing blemish in a child. The cavernous and strawberry types respond satisfactorily in nearly all cases to radiation therapy and should be treated as early as is practicable." He has never seen a case of spontaneous regression. We also agree with him that the strawberry type of hemangioma, as well as the cavernous hemangioma, usually responds well, while the so-called portwine stain is not amenable to radiation therapy.

Summary

1. Two cases of cavernous hemangioma treated by radium, with follow-up periods of 6 and 13 years respectively, are discussed.

2. The strawberry type of hemangioma and the cavernous hemangioma usually respond well to irradiation; the so-called portwine stain does not.

(E. A. P.) 1300 University Avenue.

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UNIVERSITY OF WISCONSIN INSTITUTES RESEARCH UNIT FOR STUDY OF AMYOTROPHIC LATERAL SCLEROSIS

Physicians Urged to Refer Patients for Evaluation

A research unit for the study of amyotrophic lateral sclerosis and allied disorders has been established at the University of Wisconsin Medical School. It is supported and financed by the Detling Foundation and is currently under the leadership of Dr. Peter L. Eichman. Participating in the study are: Dr. P. Settlage and graduate student R. P. Bunge in the Department of Anatomy, Dr. G. ZuRhein of the Department of Pathology, and Drs. Hans H. Reese and Henry A. Peters of the Department of Neuropsychiatry.

The primary purpose of the study is an advance in the knowledge of this clinical disorder, its possible etiologic mechanisms, and the use of the various therapeutic measures. Arrangements have been made for the evaluation of patients suspected of having this disease. Patients may be seen as outpatients for immediate evaluation, though admission to the hospital for detailed clinical studies is carried out in the usual manner for hospitalization to the University Hospitals at Madison 6, Wisconsin.

If you have patients with the spinal form with its muscular atrophy, fasciculations, and spastic weakness of the legs, without sensory disturbances, or the bulbar type with dysphagia, nasal speech, fasciculations of the tongue, and the like, we should be most interested in evaluating the syndrome as a part of our program of study for you. Full clinical reports will be sent to you following our examinations. With your cooperation we would also like to offer several types of treatment.

Corneal Transplant

By ROBERT H. LEHNER, M. D.
Racine

THIS is a report of a case of interstitial keratitis and the surgical technic of a penetrating corneal graft which improved the patient's vision from 20/200 to 20/20.

Case Report

S. B., at the age of 12 years, was first seen on January 24, 1948, at which time she was in the acute stage of a bilateral interstitial keratitis. Her vision at that time was reduced to seeing hand movements with the right eye and was 20/200 in the left eye. The following day she was hospitalized and given typhoid vaccine fever therapy and penicillin injections. Within a few days the vision in both eyes was reduced to seeing hand movements. We contacted the local health officer, and the patient was sent to Chicago for intensive antiluetic therapy. We next saw her on March 12, 1948; and her vision was still reduced to seeing hand movements with each eye. The local social hygiene clinic continued treating her with arsenicals and bismuth injections. During the next six years, we saw this patient several times each year.

On June 1, 1954, the vision in her right eye was 20/200 and in the left eye 20/100. The patient was at this time 18 years of age. There was considerable opacification of the cornea of both eyes, with numerous ghost vessels and many fine vessels, especially at the periphery. The Wassermann was still positive; she had had adequate antiluetic treatment and was supposedly "cured" but "Wassermann fast."

Donor Eye

Early on June 12, 1954, a 44-year-old patient suddenly died at a local hospital; and we received permission to remove her eyes to use for corneal transplantation. The eyes were both removed under sterile technic and refrigerated. Eyes for this purpose should be removed within a few hours after death and used within 48 hours, but preferably within 24 hours. One of the donor's eyes was used in this case, and the other was sent via Capitol Airlines to New York, where it was used the following morning for a corneal transplant.

Preoperative Preparation

As soon as we obtained the donor eye, the patient was called from her work and hospitalized. The preoperative preparation was similar to that used in cataract surgery except for the miotic. A blood count and urinalysis were done, the patient received a penicillin injection, 1 per cent pilocarpine was instilled in the eye, and a hypo of Demerol and atropine was given.

Anesthesia

One per cent Novocaine, with Adrenalin and hyaluronidase, was injected into the orbital margins for akinesia, retrobulbarly, and subconjunctivally around the limbus. A general anesthesia of Sodium Pentathol was administered.

Surgical Technic

Fixation sutures were placed through the episclera near four and eight o'clock limbus, and a superior rectus suture was used. With a Castroviejo trephine, a 6.5 mm. corneal graft was taken from the donor eye, and one 6–0 black silk suture was inserted through the edge. With the same trephine, a corneal section was partially made in the recipient eye and was cut free with Katzin corneal scissors. There was a small amount of bleeding from small vessels at the corneal incision. The donor cornea was placed in the recipient eye and sutured edge to edge with twelve 6–0 interrupted black silk sutures. No overlying figure of eight sutures were used. Terramycin ointment was applied, and only the operated right eye was bandaged.

Postoperative Care

The patient was given daily injections of 600,000 units of penicillin for 10 days. This was done, at the suggestion of the local health officer, because of the positive Wassermann. The patient was permitted to sit up in bed on the first postoperative day and was allowed out of bed on the following day. Al-

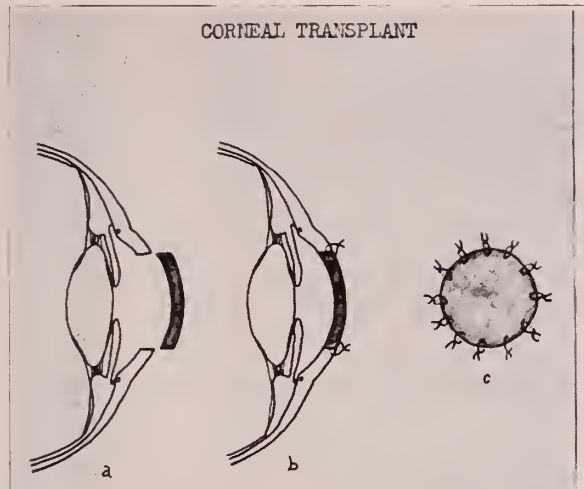

Fig. I. Diagram (a) Shows the relative size of a 6.5 mm. corneal graft. (b) Shows the depth of the direct edge to edge sutures. (c) Shows the 12 interrupted 6-0 black silk sutures.

Fig. II. S.B. age 18. Interstitial Keratitis, 11 days preoperative. Note the corneal cloudiness which reduced vision to 20/200

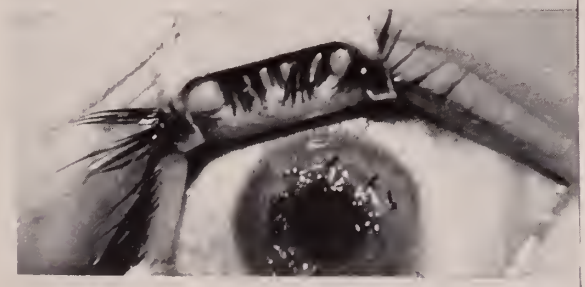

Fig. III. Corneal Transplant 9 days postoperative. Several sutures have worked loose and the graft is moderately cloudy.

Fig. IV. Corneal Transplant 19 days postoperative. Pupil still dilated. Graft clearing. The white spot near the center of the cornea is a reflex from the light.

Fig. V. Corneal Transplant 54 days postoperative. Graft clear. Vision 20/20 with correction.

Fig. VI. Corneal Transplant of right eye 54 days postoperative. Note the clear pupillary area of the right operated eye compared to the cloudy cornea of the left eye.

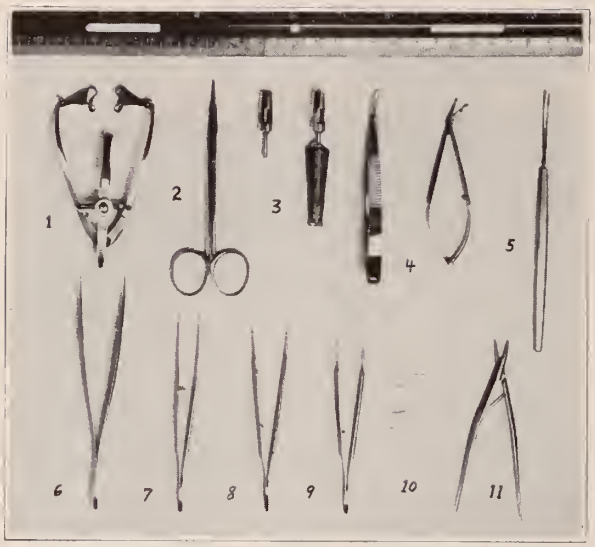

Fig. VII.—Corneal Transplant Instruments: 1. Guyton-Park speculum. 2. Suture scissors. 3. Castroviejo 6.5 mm. corneal trephine. 4. Katzin right and left curved corneal scissors. 5. Spatula. 6. Thorpe corneal forceps. 7. Castroviejo suturing forceps. 8. Forceps with serrated point. 9. Forceps with mouse teeth. 10. Grieshaber 7 mm. corneal needles with 6-0 black silk. 11. Green needle holder.

though the unoperated left eye was not bandaged, the patient attempted to use it very little during the first week following surgery. The first dressing was done on the second postoperative day; the corneal graft was slightly cloudy, the pupil was small, the anterior chamber was well formed, and the graft was in good position. At each daily dressing, 1 per cent atropine solution, 10 per cent Neo-synephrine solution, and cortisone-bacitracin ointment were instilled in the operated eye. The patient had very little postoperative pain except at the time of changing the eye dressing. She was a "squeezer," and one-half per cent Pontocaine and a hypo of one-half grain of codeine were necessary to examine the eye for the first week or so.

On the ninth postoperative day, the patient was given a general anesthetic of Sodium Pentathol; and all of the corneal sutures were removed. The eye was carefully examined at this time, and a small amount of blood was seen in part of the incision. There were no postoperative complications, and the patient was permitted to go home on the fourteenth postoperative day. She was kept on atropine solution and cortisone solution for about a month postoperatively. A slit-lamp examination showed that the corneal vascularization had not extended into the graft but ended at the corneal scar. No beta radiation was used either before or after surgery.

A cycloplegic refraction was done about six weeks postoperatively; and with a correction of $-1.50 + 4.50 \times 110$, the patient was able to read 20/20.

Conclusion

No attempt has been made to include either the indications for keratoplasty or the various types and technics of this procedure. This has been the report of a case of interstitial keratitis and the surgical technic of a penetrating corneal graft.

312 Seventh Street.

FILM ON CLEFT PALATE CHILD AVAILABLE

A new movie, "The Wisconsin Cleft Palate Story," in sound and color, has been produced by the Bureau for Handicapped Children, Department of Public Instruction, in cooperation with the University of Wisconsin Medical School, Department of Speech, and University Hospitals. It shows the integration of services necessary in the habilitation of a cleft palate child. This 36-minute film tells the story effectively and honestly.

The film can be rented from the Bureau of Visual Instruction, University of Wisconsin, 1323 West Johnson Street, Madison, Wisconsin, for a nominal fee. It is available for purchase through the Photographic Laboratory, 1204 West Johnson Street, University of Wisconsin Extension Division, Madison, Wisconsin.

Anesthesia Emergencies Confronting the General Surgeon*

By ALLAN E. TALBOT, M. D.
Neenah

THIS topic has caused me real concern. I had trouble deciding just what to call an emergency; each of us uses this word in a different way. It is the thing you're going to when the police patrol gives you that "what's the hurry?" routine. It is the reason you're aroused at 3:00 a.m. while most people in their right minds sleep until at least 6:00 a.m.

Seriously, though, a number of situations may develop during the course of anesthesia and operation which, if untreated, could lead to very serious or fatal complications. The lessons to be encountered here are best directed to the surgical team as a unit rather than to any particular member.

Rather than skipping lightly over the many bothersome and unfortunate situations which could arise during anesthesia and operation, I will limit my discussion to a few main troubles we sometimes encounter. If it seems as if you had heard this song before, remember what our older teachers have said, "There is nothing new in anesthesia which should trouble you if you have learned the lessons from the past."

Aspiration

One of the main problems confronting the anesthesiologist is that of the patient who has eaten on the day of his operation prior to coming to the operating room so that there is the danger of aspiration of vomitus. The presence of food in the stomach, the apprehension or fear of the operation, and anesthesia itself contribute to the tendency to vomit. At the same time, the usual protective throat reflexes, including pharyngeal, epiglottic, and laryngeal are more or less abolished so that gastric contents deposited in the pharynx can easily be drawn into the tracheobronchial tree. Death may be immediate and, being unnecessary, is extremely tragic.

Anesthesiology, with all its progress, has not been able to deal with this problem completely, to remove it entirely from the mortality statistics. The anesthetist is too often unwillingly drawn into the situation of putting this patient to sleep. Many of the so-called emergency operations could and should be postponed until the next day. "The next day" is a rule which could eliminate almost all of the deaths due to aspiration of vomitus. It is unfortunate that there is so much difficulty in realizing this before the operation; after a fatal mishap, it is almost always obvious that waiting until the next day would have been easily possible.

The usual solution is to wait four or five hours after a patient has eaten. The fallacy in this is that the stomach does not empty in five hours and is particularly slow with pain, after a painful injury, or in pregnancy, the most frequent indications for emergency surgery. Attempting to empty the stomach with a nasogastric tube is futile. Only some of the liquid contents are removed, leaving the more dangerous solid particles behind.

Gastric contents in the tracheobronchial tree are dangerous for several reasons: (1) they cause immediate respiratory obstruction (this is by far the greatest danger); (2) they may produce infection and focal atelectasis; and (3) the acid content may produce edema of the respiratory tract.

A stomach which is not known to be empty must be regarded as full. If you are compelled to operate on these patients, all efforts must be made to prevent aspiration.

Whenever possible, operation should be performed under some form of local or regional anesthesia so that the patients retain the protective laryngeal and pharyngeal reflexes. When it is absolutely necessary to use general anesthesia, endotracheal intubation should be done as quickly as possible with a snug-fitting or, preferably, a cuffed endotracheal catheter.

Since this patient is being put in danger of his life, the nature and urgency of the operation should merit a secondary role.

Cardiac Arrest

This situation has received about as much publicity as any other I can think of—in both general and specialized medical journals.

*Presented at the One Hundred and Thirteenth Annual Meeting of the State Medical Society of Wisconsin, October 5, 1954.

It is now appreciated that the major causes of cardiac asystole and ventricular fibrillation are hypoxia of the myocardium and reflex mechanisms initiated through vagal stimulation. The best prevention is the maintenance of a constant stream of highly oxygenated blood through the coronary vessels. Therefore, anything which interferes with the airway, depresses respiration, or decreases blood flow may set the stage for cardiac arrest. Even though a heart may be revived to carry on its physiological duties, too much delay in re-establishing circulation leads to cerebral anoxia and irreversible damage to the cerebral cortex. Cardiac arrest must be treated promptly to obtain a return to normal function, not merely of the heart itself, but of the patient as a mentally competent human being.

Technics: Among the technics needed in cardiac resuscitation are:

1. Artificial respiration with 100 per cent oxygen.
2. Cardiac massage.
3. Administration of intravenous fluid and blood.
4. Administration of drugs.
5. Defibrillation by means of electric shock.

The need for instituting cardiac massage (or manual artificial circulation) in the instance of cardiac arrest is well established. Most authorities agree that the optimum time to begin direct massage is within three minutes of cessation of cardiac activity. The usual and best approach is through an intercostal incision in the left fourth interspace.

Fluids can be administered intravenously under pressure if necessary; but some workers believe the intra-aortic route for transfusion is most advantageous, especially if cardiac arrest has followed a period of exsanguination and there is inadequate refill of the heart.

The use of drugs in cardiac resuscitation still remains a controversial issue. Procaine (1 per cent, 5 to 10 cc.), given intravenously and repeated every two to four minutes, and epinephrine (intracardiac) in 0.2 cc. of 1:1000 solution are the most frequently used to restore cardiac activity.

Needling of the heart repeatedly through the chest wall has been tried with some success while preparing for a more radical approach.

The most important factors in cardiac resuscitation, however, are the availability of the materials to institute the resuscitation and the personnel to use them quickly and wisely with a full understanding of the problem they are facing.

Cortisone

The extensive use of cortisone and corticotropin has created a new problem for the operative team. It has been established that the administration of cortisone tends to cause atrophy and suppression of function of the adrenal cortex so that periods of stress such as anesthesia and operation may lead to acute adrenal insufficiency and endanger the life of the patient. It has been demonstrated that this suppression may persist for an appreciable period of time after administration of exogenous corticotropin. The many questions which arise must be answered in a relative way, depending on the individual response to cortisone therapy and on the severity of the stress which necessitates the increased adrenal cortical activity. If the cortisone dose could be titrated to fit the existing deficiency, there would be, theoretically, no suppression of the remaining function of the pituitary adrenal system. This is not the situation in practice, however, so we must take precautions to eliminate the possibility of an acute episode. It is well to prepare each patient with a history of cortisone therapy within a period of six months by giving 200 mg. of cortisone, intramuscularly, 48, 24, and 2 hours preoperatively. This will serve as a depot of cortical hormone during and immediately after operation.

The anesthetic agent and the technic used do not seem to be major factors. All efforts should be made to minimize the stress of anesthesia. In this respect, your approach will accomplish as much as your choice of agent and technic.

Whether or not the patient has had any special preparation, sudden acute adrenal insufficiency should be considered a possibility during an operation in any patient who has had cortisone therapy. Preparations of cortisone or hydrocortisone for intravenous use, as well as large amounts of aqueous adrenal cortical extract, should be available. Vasopressors, whole blood, or plasma expanders should be available to

treat shock. Since adrenal failure is most likely to occur in the first 24 hours postoperatively, the postanesthesia and postoperative care must likewise be carried out with the ever-present possibility in mind.

Acute adrenal insufficiency in the postoperative period will most likely appear with a profound drop in blood pressure which does not respond to routine measures. There may be a rise in body temperature, and the patient may lose consciousness. Treatment should be instituted immediately by the administration of large volumes of adrenal cortical hormone and all measures ordinarily used to combat shock, 100 mg. of hydrocortisone or cortisone dissolved in 500 cc. saline and given intravenously, and another 200 mg. of cortisone given intramuscularly. Vasopressors such as Neo-synephrine should be given to control hypotension, and whole blood or plasma expanders should be used to increase plasma volume.

The picture is not as dismal as it may seem. Many patients in the past who have had varying amounts of cortisone therapy have undergone anesthesia and operation without any difficulty. Also, there are no reported cases of acute adrenal insufficiency during or after anesthesia and operation in patients who are receiving adequate cortisone therapy.

Conclusion

Almost all of the anesthesia emergencies (or, better, intra-operative emergencies) which we encounter can be traced to something we overlooked or to a lesson we failed to heed. Each anesthesia administration is actually a physiological experiment, and it is our experience and skill and observations that keep it from becoming a physiological insult.

P. O. Box 563.

MEETING OF WISCONSIN CHAPTER OF INTERNATIONAL COLLEGE OF SURGEONS

The spring meeting of the Wisconsin Chapter of the International College of Surgeons will be held from 12:00 to 2:00 p.m. on Tuesday, May 3, at the Crystal Ballroom, Hotel Schroeder.

Following is the program scheduled for the meeting:

1. Introduction of Dignitaries and Members
2. Scientific Program (Moderator, Arnold S. Jackson, M. D., Madison)
   a. "Ankle Fractures"—J. M. Regan, M. D., Milwaukee
   b. "Management of Toxic Surgical Thyroid"—Karl Schlaepfer, M. D., Milwaukee
   c. "Preparation of Patient, Managemental Problems in Intestinal Surgery" —Martin Malensek, M. D., Milwaukee
   d. "Surgical Congenital Anomalies and Case Presentation of Congenital Absence of Vagina"—E. A. Habeck, M. D., Milwaukee

   Each of the topics will be a 15-minute presentation, followed by a 5-minute discussion period.
3. A Word About I.C.S.—Phillip Thorek, M. D., Chicago
4. Business Meeting (Members only)

Version and Manual Dilatation*

AMONG the facts brought to light by the study committee of the Wisconsin maternal mortality survey was the frequent occurrence of manipulative procedures such as manual dilatation, version, and breech extraction among these fatal cases. The study committee was impressed by the frequent association of these manipulations with ruptured uteri and death.

The indications for version are few; its sphere of usefulness has shrunken. When one considers that the occasions when it becomes a necessary procedure nearly always arise in multiparous mothers, the risks involved must be seriously thought out. The deaths in the group studied were in women who had from one to twelve other children.

What is version? It is the change of polarity of the fetus *in utero*, accomplished by external or internal forces.

Version can be external cephalic version. By external manipulation through a thin abdomen with no resistance from an irritable uterus, the polarity of the fetus is changed. This is attempted late in pregnancy before the presenting part has engaged, when faulty lie of the fetus is discovered through careful and intelligent prenatal care. It is thought by some to be more favorable to effect a version than to attempt to deliver a breech, if factors such as size of the head and adequacy of the outlet are favorable. However, there must be no false security. Dangers to the fetus and the mother are inherent in this maneuver. The exact toll to the fetus can probably never be fully ascertained. One questions whether the dangers of external version are not greater than those in delivering a breech intelligently and carefully as a breech. Certainly, an attempt at the maneuver is well justified when the transverse lie discovered late in pregnancy persists. It is extremely important at all times that careful attention be directed toward any change in the character or the quality of the fetal heart.

Internal version, also known as podalic version, constitutes a most valuable obstetrical maneuver when well chosen and carefully managed. If mismanaged, it can become a treacherous and death-dealing procedure to both the infant and mother. As in external version, its greatest application again exists when a transverse lie is discovered late in the labor of a multiparous patient. Under these circumstances, with the cervix completely dilated and the patient completely anesthetized, the feet of the fetus can easily be grasped and the version slowly and carefully accomplished. Breech extraction then follows. The choice of dislodging a vertex presentation to effect a version and extraction is much debated. The occasional persistent posterior, the parietal presentation, or the much-dreaded face presentation may pose such a problem when the pregnancy is single and at term. Also debated is the part that version plays in the delivery of the second twin. Some teaching institutions routinely use this procedure as a means of teaching technic of version. We believe that the added hazard does not justify the end. Statistics gathered in one large Wisconsin hospital reveal the fact that 50 per cent of the neonatal deaths in twins were accounted for by the delivery of the second twin by version. It has been the experience of some that after the first twin has been delivered, it is no problem to rupture the membranes which are bulging before the second head and to guide it gently down the canal, with the result that it will often deliver spontaneously.

When the decision is made for podalic version, the following essentials of caution must be observed:

1. The size of the birth canal must be compatible with the size of the head of the infant. Version is not a procedure which permits by some mystic charm connected with its very name the safe and easy conduct of a mammoth infant through a borderline or normal-sized pelvis. Deliveries of a normal-sized infant through this type of pelvis may safely be effected.

2. The cervix must be completely effaced and completely dilated. Again, version is not a miracle procedure which enables the foot, the thigh, the buttocks, the shoulders, and finally the head to be wedged through

* Prepared for the Study Committee of the Wisconsin Maternal Mortality Survey by F. J. Hofmeister, M. D., assistant clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee.

an unready, incompletely dilated cervix. If the cervix is not ready and the condition of the mother or the infant or both requires immediate delivery, a decision must be made for a different method, the cesarean section.

3. Anesthesia must be well chosen, and a state of complete surgical anesthesia must exist. Saddle block, local infiltration, or caudal anesthesia are poor choices. The whiff of gas or the poorly administered anesthesia is a hazard rather than a help. We should exercise the same care, precision, and consideration in the administration of the anesthetic in the obstetrical case as is exercised in its administration in the complicated gynecological or general surgical case. This must become a reality before maximum progress is realized in the reduction of maternal mortality.

4. Theoretically, version is more effectively done if the membranes are unruptured and a maximum of amniotic fluid exists. The uterus then is more distended, is not as irritable, and does not cling to the body of the fetus. The chances for rupture of the lower uterine segment are greatly reduced.

Combined version, also known as Braxton–Hicks' version, is at times attempted when partial placenta praevia exists; the version is executed by several fingers of one hand inserted through the partially dilated cervix, with the other hand assisting through the abdomen. The hazard of manual separation of the placenta is real. This procedure seems to be best relegated to the same distinction afforded other obstetrical gymnastic feats and might well be placed on the shelf of antiquity along with the Voorhees bag.

What, then, are the big problems of version besides the selection of the case? Foremost is the excitement and emotional pressure when there is a complication which needs action. This often results in thoughtless speed, with resultant cervical laceration either done manually at the start of delivery or by the force of the actual delivery. Also, a site of laceration is the lower uterine segment; laceration may occur as the result of too rapid or too forceful version or because of the very nature of the scarred and traumatically thinned lower uterine segment.

Multiparity, contrary to popular belief by both patient and physician, carries many hidden and unaccepted dangers.

Far too many infants and many mothers are lost because anxiety and desperation result in the improper choice of version when careful evaluation and a more thoughtful decision might have resulted in the choice of another obstetrical maneuver or of cesarean section, with resultant salvage.

Manual Dilatation

Where does manual dilatation fit into the jigsaw of obstetrics? Unfortunately, many times when version is the choice, it is done with the cervix dilated 4 to 6 cm. and uneffaced, contrary to all that has been taught in obstetrics for many years. Sufficient time may not have elapsed for an adequate trial labor. The progress of labor may have stopped. Another method of delivery may be necessary. There is no entity known in obstetrics as manual dilatation; correctly termed, this is manual laceration. Eastman, like all who are authorities in obstetrics, mentions manual dilatation only to condemn it. Lifting the occasionally trapped anterior lip of the completely dilated cervix which is impinged between the presenting head and the symphysis is not to be confused with the so-called manual dilatation.

In rare instances a rim of cervix persists, and the condition of either mother or fetus demands intervention. The head is well engaged into the canal, and there is no question of disproportion. Under these conditions, the Dührssen incision has been recommended. This procedure carries with it real hazard immediately and, in some instances, latent hazard, since imperfections of the cervix have been known to persist and result in a mechanical infertility.

Finally, when version has been effected or whenever difficult or unusual obstetrical procedures have been employed, the cervix should be inspected. Under these conditions, also, a more liberal use of interuterine palpation is justified, if carefully executed. Death from hemorrhage when an unrecognized and untreated ruptured uterus and laceration exist is a far greater possibility than death from infection as the result of careful cervical visualization and interuterine palpation.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

What two failures reported during the past year have caused considerable disappointment in the field of cardiovascular therapy?

The first was the failure with quinidine. In the report of W. R. Hansen, R. L. McClendon, and J. M. Kinsman from the University of Louisville,[1] there was suggestion of a relaxing effect of quinidine on the peripheral vessels of sufficient degree to account, apparently, for a fall in peripheral resistance in 9 of 14 patients. In work with dogs, Go Lu, at Stanford University,[2] found quinidine, in dosage insufficient to cause significant cardiac depression, productive of considerable peripheral vasodilatation and fall in blood pressure. These things led one to hope that the drug might find a place in the therapy of essential hypertension. But this hope seems to have been completely dashed by A. W. Seligmann, F. C. Ferguson, Jr., S. Garb, J. L. Gluck, S. L. Halpern, and M. Goodgold in New York City;[3] they performed a double-blind clinical experiment in which the effects of quinidine and quinine were compared with those of a placebo, neither patient nor attending physician being aware of the nature of the therapy. Alternate four-week courses of quinidine sulfate and placebo were given to 44 patients; 21 received quinidine followed by a placebo, and in 23 the order of administration was reversed. After completion of the quinidine-placebo study and at least two additional weeks without treatment, 18 patients were carried through similar four-week courses of quinine and placebo. In 10 cases quinine was given first, and in 8 placebo. Neither quinidine nor quinine was of the slightest specific benefit, whether patient's opinions of their general health, physicians' evaluation of clinical course, or status of individual symptoms, was considered. In each case, apparent benefits induced by the alkaloids were equaled by those ascribed to the placebo.

The second disappointment came in the attempt of E. P. Simon and I. S. Wright of New York City,[4] to confirm the finding in the preliminary report of H. Engelberg and T. B. Massell of Los Angeles[5] that heparin was considerably effective in relieving intermittent claudication in a small group of patients with advanced peripheral atherosclerosis. The New York workers tested six patients with arterial insufficiency on an electrically driven treadmill ergometer at about the same hour of the same day each week. After sitting quietly for 30 minutes, the patient mounted the treadmill, started it himself, and walked as long as he could, the mill being set at a rate at which intermittent claudication always developed. When he could no longer walk because of claudication, the patient stopped the machine by pulling the switch. Placebo or heparin was then injected intravenously, and the procedure was repeated after a rest. An average of the two claudication times was recorded. The one observer, who usually did not know which medication was being given, remained out of sight and of communication and measured the time with a stop watch. The patients did not know what medication they were receiving or their claudication times. Medication, given intravenously twice weekly, consisted of isotonic sodium chloride solution, 2 cc., or heparin sodium solution, 50 mg. per cc. sterile isotonic solution, 2 cc. All subjects had stopped smoking at least two months before, no medication other than heparin or placebo was given, and observation periods ranged from 12 to 24 weeks. In none of the subjects who received intermittent heparin therapy was there any alteration in subjective symptoms, physical findings, or claudication times that was related to administration of the drug.—HARRY BECKMAN, M. D.

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ARE YOU USING THESE GUIDES?

The divisions, committees, and councils of the State Medical Society of Wisconsin, in cooperation with various voluntary and governmental agencies, have been responsible for the development of numerous guides and manuals related to certain aspects of medical practice. While these have been made available to every member, it is quite possible they may not be at hand when the occasion arises for their use.

The following guides and manuals are available upon request to the State Medical Society office:

1. **Adoption Procedures in Wisconsin**—A reminder of statutes governing adoption proceedings and a guide to agencies serving the unwed mother or married parents seeking to place a child for adoption.

2. **Civil Defense Manual for Mobile Medical Team Personnel**—An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.

3. **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

4. **Ethical Practices in Reference to Workmen's Compensation and the "Open Panel Program"**—A guide for the use of physicians, industrial nurses, management and insurance carriers in handling consultation, reports, complaints, and free choice of physician in relation to the compensation program.

5. **Guide for the Development of a Local or Regional Rheumatic Fever Program**—Recommendations for a model plan of rheumatic fever program emphasizing the convalescent home, diagnostic and follow-up clinics, and a home-service program.

6. **Hearing Conservation Programs for Wisconsin Industries**—Some recommended standards and principles for providing a hearing conservation program in industry.

7. **Industrial Health, A Guide for Medical and Nursing Personnel**—General principles and suggested procedures for an industrial health program, especially in relation to standing orders for nurses.

8. **Medical Care of Migrant Agricultural Workers**—A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.

9. **Membership Manual of the State Medical Society of Wisconsin**—A manual on membership and dues problems of the State Medical Society and the American Medical Association. Primarily for the assistance of county medical society officers.

10. **Minimum Standards of Medical Care for County Hospitals**—A guide to physicians and county asylum superintendents concerning medical care for patients in county hospitals.

11. **Participation by Physicians in Radio and Television Programs**—A guide to physicians and county medical societies for their presentation of or participation in radio and television programs.

12. **Planning Your Career as a Medical Associate**—A brochure to acquaint young people with the careers open to them in fields related to medicine.

13. **School Health Examinations**—A guide for physicians and school authorities in establishing a program of school health examinations.

14. **School Vision Screening Program**—An outline to facilitate the development of a program to detect significant visual defects among school children.

15. **Standards for Management Services Desiring to Advertise in the Wisconsin Medical Journal**—A list of standards under which the Wisconsin Medical Journal will accept advertising on behalf of management services for physicians.

16. **Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers**—A list of the objectives of the State Medical Society in devising the Wisconsin Plan and the conditions under which insurance carriers may participate in that plan.

17. **Wisconsin Physicians Service Manual**—A guide for physicians and their office assistants in servicing contracts held by subscribers to the Blue Shield Plan of the State Medical Society of Wisconsin.

18. **Wisconsin Veterans Medical Service Agency Schedule of Fees**—A description of the Wisconsin Veterans Medical Service Agency of the State Medical Society, instructions on arranging "home-town" care for veterans with service-connected disabilities, and the schedule of fees negotiated with the Veterans Administration.

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Bronchopulmonary Infection
Acute Pyelonephritis
Chronic Pyelonephritis
Mixed Bacterial Infections
Soft Tissue Infections
Staphylococcal Septicemia
Pneumonoccal Septicemia
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Clinicopathologic Conference

Sponsored by the Section on Pathology, State of Wisconsin Medical Society
Guest Editor: D. M. Angevine, M. D.

REPORT OF A CASE*

History: A 41-year-old, white female was admitted to the Neurology Service for the first time on February 5, 1954. Pain in her right leg, with edema and an inability to void, had developed on January 20, 1954. She was admitted to another clinic in Wisconsin at that time with a history of severe vaginal bleeding in the preceding several months. They reported an obviously chronically ill, white female with a blood pressure of 160 90, generalized pallor, and a large mass in the pelvis which was interpreted as a distended bladder containing 1,500 cc. of clear, yellow urine. After decompressing the bladder, they palpated a large firm nodular mass the size of a six months' gestation on the right side of the pelvis. The cervix could not be checked because of a virginal introitus. Examination of the rectum revealed a hard mass filling the sacral concavity and exerting extrinsic pressure on the rectum. The patient was able to move her lower extremities fairly well at the time of her admission here.

Laboratory studies at another hospital revealed a hemoglobin of 4.6 Gm., with 3,300,000 red blood cells and 1,200 white blood cells. X-ray of the chest was negative for metastatic lesions. She received multiple transfusions, and on January 25 a bilateral salpingo–oophorectomy was done. A large cystic ovary on the right and a uterus which was filled with large subserous, intramural, and submucous masses were removed. Cystoscopy previously had revealed no direct involvement of the ureters or bladder, except by extrinsic pressure. Direct examination at that time revealed that the liver, gallbladder, spleen, kidneys, stomach, and bowels appeared to be normal.

A paralytic ileus was observed after surgery. Signs of spastic paraplegia, hyperactive reflexes, bilateral Babinski, and inability to void also developed postoperatively. In view of the above complications, the patient was referred to this hospital. She was admitted on February 5, 1954. A review of the systems, past history, and family history revealed no significant abnormalities.

Physical Examination: Examination revealed a mentally dull, obviously chronically ill, white female who was afebrile. There was one *café au lait* spot beneath the left breast. The remainder of the physical examination revealed no abnormalities except for generalized pallor and a distended and tympanitic abdomen with a recent, lower-midline scar. Neurologically, the patient presented a complete paraplegia, with a sensory level at or just below the nipples. Reflexes in the lower extremities were bilaterally hyperactive; the Babinski signs were present, also.

Laboratory Studies: Laboratory studies at admission revealed a very mild pyuria with an alkaline urine. A hemoglobin of 11.4 Gm., with approximately 5,000,000 red blood cells and 11,100 white blood cells, was observed. The differential count was 68 polymorphonuclear cells, 11 immature neutrophils, 1 eosinophil, 13 lymphocytes, and 7 monocytes. The sedimentation rate was 45 mm. per hour. Blood sugar, nonprotein nitrogen, acid, and alkaline phosphatase and cholesterol studies were all within normal limits. The patient had a spinal fluid protein of 800 mg. per cent shortly after admission. A urine culture revealed proteus vulgaris and gram-negative bacilli. Total serum protein, Hanger's tests, and thymol turbidity were within normal limits. X-rays of the chest, skull, and dorsolumbar spine were also within normal limits, as was the electroencephalogram. The ophthalmological examination revealed no significant abnormalities in the fundi except early hypertensive changes.

Course: A fever of 104 F. developed shortly after the patient's admission. On February 10, a myelogram gave evidence of complete block at the level of the seventh dorsal vertebra. A decompressive dorsal laminectomy of the fourth, fifth, sixth, sev-

* From the University Hospitals and University of Wisconsin Medical School.

enth, and eighth dorsal vertebrae was performed; after this the patient did satisfactorily for three days except that she had a fever. On February 15 a slight anisocoria was noted and also, for the first time, a lower left facial weakness with mild weakness in the left upper extremity. No sensory deficits were noted. From this point on, there was gradual deterioration, and the patient expired on March 19, 1954. She had shown progressive paresis of the left extremities and increasing somnolence. During her postoperative course she had had several episodes of fever.

Clinical Discussion

Dr. R. F. Schilling: This 41-year-old woman died approximately six months after the onset of her last illness. The initial symptom was severe vaginal bleeding. The symptoms which brought her to her physician were pain in the right leg, edema, and the inability to pass urine. Physical examination at that time revealed a large, firm, nodular mass in the lower abdomen. Laboratory studies revealed evidence of a severe hypochromic anemia. Surgery for the lower abdominal tumor consisted of the removal of a large cystic ovary and a tumorous uterus. It is not clear whether the tumors were considered benign or malignant. From the history, I favor a malignant tumor since it would be most unusual for uterine fibroids to cause pain, edema, and inability to void. Postoperatively, the patient developed signs of spastic paraplegia with hyperactive reflexes and bilateral Babinski signs. The inability to pass urine persisted.

At the time of entry into the University Hospitals in February of 1954, the patient presented a complete paraplegia and a sensory level at or just below the nipples. The location of this sensory level indicates involvement of the spinal cord at the level of about the sixth dorsal vertebra. Spinal cord tumors involving the dorsal segment of the cord characteristically cause hyperreflexia. The Babinski toe signs would fit with this picture. Spinal fluid removed shortly after the patient's admission to this hospital showed an extremely high protein and slight xanthochromia; these findings are entirely consistent with intra- or extradural tumor. No cells were seen in the spinal fluid.

A fever of 104 F. developed. This could be interpreted as due to urinary tract infection in a patient with stasis. The dorsal laminectomy revealed a large tumor. A few days after this surgery, progressive weakness of the left arm and face developed. This was most likely due to rapidly growing intracranial metastases.

The exact type of primary neoplasm is, of course, not predictable; but one would think that carcinoma of the uterus or ovary would be the most likely possibilities.

Dr. M. Javid: We saw this patient in consultation on February 11, 1954. The neurological examination indicated involvement of the spinal cord at about the level of the sixth dorsal vertebra, and the Pantopaque myelogram which had been done shortly before we saw her showed a complete block at the level of the seventh dorsal vertebra. It was our impression that we were dealing with a rapidly growing extradural tumor at this level. We considered an epidural abscess but favored a neoplasm. We proceeded with a thoracic laminectomy immediately and found a hard fibrotic extradural mass involving the sixth and seventh thoracic vertebrae. The mass had caused a very marked compression of the spinal cord at this level. A generous decompression laminectomy was done. I might add that we did not consider pelvic organs as a primary site since the microscopic report of previous laparotomy showed "endometriosis of the ovary with a chocolate cyst, leiomyomata of the uterus, and a nonsecretory endometrium but no evidence of malignancy."

The patient tolerated the laminectomy well. Her subsequent course, however, indicated metastatic lesions of the brain. We did not consider further neurosurgical procedures to be justified.

Dr. W. H. Jaeschke: I examined a hard fibrotic epidural mass from the seventh thoracic vertebra. The frozen section examination suggested a leiomyoma or leiomyosarcoma. The paraffin sections indicated that the differential diagnosis should include a consideration of leiomyosarcoma and neurofibrosarcoma. Based on the location of the mass and the limited clinical information available at the time, the latter diagnosis seemed more logical. Subsequent studies and additional information caused us to alter our opinion in favor of leiomyosarcoma.

Necropsy Findings

(University Hospitals 54:91)

Dr. D. M. Angevine: Only the principal autopsy findings will be given.

Numerous adhesions were observed between loops of intestine. The pelvis was completely filled with white, gritty tumor tissue. The pelvic organs, except for a small portion of the uterus, had been removed. The tumor constricted the left ureter; the right ureter and rectum were not involved.

In the thorax there were a white, firm tumor nodule about 2 cm. in diameter on the left side of the seventh dorsal vertebra and a smaller nodule on the right side. A tumor similar to the latter was observed at the angle of the third right rib.

The heart showed no lesion. Numerous small nodules up to 0.5 cm. across were felt in the left lung. A single nodule, 1 cm. across, was observed in the left lobe of the liver.

There was a large abscess about 10 x 4 x 3 cm. on the posterior surface of the left kidney; it communicated with the renal calyces. The renal pelvis was dilated, and the calyces were covered with a purulent exudate. The left ureter was dilated to 1 cm. and contained a purulent exudate. The wall was thickened due to obstruction by the pelvic tumor.

The spinal cord was removed, and tumor tissue was observed extradurally at the operative site. The decompression of the cord was adequate. Transverse sections through the cord showed a hemorrhagic lesion in the anterior gray matter in the region clinically incriminated. The principal lesion of the brain was found in the pons, which had been almost entirely replaced by a firm, gray-yellow nodule, 3 cm. in greatest diameter.

Microscopic examination revealed that the pelvic tumor, the nodules in the liver and the lung, the extradural tumor over the cord, and the pontine tumor were all similar histologically and represented a leiomyosarcoma. Additional microscopic metastases were observed in sections of brain from the frontal and parietal cortex and about the third ventricle.

About 4 per cent of all malignant tumors of the uterus are sarcomata. A leiomyosarcoma may commence as a fibroid with subsequent sarcomatous degeneration, or it may arise directly as such from the smooth muscle fibers of the uterus. The initial report of leiomyomata of the uterus at the first operation caused the physicians concerned to disassociate the pelvic condition with the findings in the spinal cord. Once the cerebral symptoms became manifest, it seemed certain that the lesions in the nervous system were metastatic. A review of the sections of both spinal cord tumor and the leiomyomata indicated a similar type of tumor, namely, a leiomyosarcoma.

BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the first half of 1955 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who come within the state's definition of a crippled child. It is preferred that referral be made by the family physician; but when this is not feasible, arrangements may be made by writing to the Bureau. Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons desiring clinic services. Medical referral forms are made up for the individual clinics, so requests should specify for which clinic forms are wanted.

Families who return the signed referral form will be notified of the day and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child; and if the public health nurse believes that the child referred to the clinic for orthopedic reasons is also in need of other services, the Bureau asks that it be notified of the fact.

Eau Claire	March 31, April 1
Wausau	April 6, 7
Sheboygan	April 13, 14
La Crosse	April 19, 20, 21, 22
Superior	April 27, 28
Fond du Lac	May 11
Appleton	May 12, 13
Chippewa Falls	May 19, 20
Rhinelander	June 1, 2
Lancaster	June 16
Darlington	June 17

Inquiries concerning these clinics may be addressed to The Bureau for Handicapped Children, 146 North, State Capitol, Madison 2, Wisconsin.

Emotional Health of Children—Accent on the Positive

As It Looks to Your State Board of Health

WE ARE living in the promising and rewarding "Century of Progress." Despite the many benefits and great possibilities, people are confused, anxious, and threatened to the point where they are skeptical of their blessings. Significantly, those who have contributed most to physical progress are among the most conscientious in seeking ways for us to enjoy better what we have. They are pointing to a solution. Charles A. Lindbergh has stated it eloquently:

"Short-term survival may depend on the knowledge of nuclear physicists and the performance of supersonic aircraft, but long-term survival depends alone on the character of man . . . . To achieve a civilization based on human values requires the desire within ourselves . . . . It must enter the roots of our being until it shapes our action instinctively as well as through the conscious mind . . . ." [1]

We naturally turn to science for some of the answers to our human dilemma. Unfortunately, much of our sparse information comes from pathology, from studies of what is "wrong" with a given child or adult; and most of our services—nowhere near ample—are set up primarily to heal damage already done.

Fortunately, there is a gradual awakening to the urgent need for something more positive. We are realizing that there definitely are causes behind people's problems. Some of these causes are now known. They provide clues to what we can do preventively for everybody rather than waiting to do "too little, too late, for too few." Based on nearly three decades of scientific study of children's development, the Institute of Child Study of the University of Toronto concludes:

". . . . the child's final well-being depends on his mental health assets rather than on his liabilities . . . . development of positive qualities is the only means of offsetting the negative effect of inevitable psychological disturbances . . . . These positive qualities are not innate. They grow through experience, and their beginnings in the young child are small, so that a careful search is necessary to be assured that their development is under way." [2]

Increasingly, there is awareness that mental health is an integral part of general health and that medicine must become more concerned with factors that help keep people well, that is, the preventive aspects of medicine. While these factors are not as yet fully identified or understood, it becomes clearer that they have much to do not only with environment and experiences, but also with the individual's reactions to them, his feelings, and his attitudes. These, in turn, depend greatly on human relations. Life experiences get their meaning chiefly in terms of our associations with other people.

This suggests a very broad base for any truly preventive program. It means that the search for, and understanding of, the psychological strengths of children is the function of all responsible adults working together in the community. "Unless mental-health principles are incorporated throughout the social structure of the local community, they are powerless to achieve their goal." [3]

How to bring about this common understanding and widespread teamwork is the key question. Without doubt, the challenge is tremendous, yet only commensurate with the need and with the potential rewards.

In some Wisconsin communities, as elsewhere in the country, the process is already in motion. There are various programs of an educational and consultative nature with the long-range objective of helping parents, physicians, nurses, teachers, clergymen, and others achieve a basis in knowledge for pooling efforts in behalf of the total well-being of all children. These programs are only small beginnings. More research and more professional personnel to guide them are required.

Perhaps we should note some of the other necessary ingredients. One is an attitude of enduring patience, admittedly hard to maintain in an impatient, fast-moving world. Another is a heightened concern with and respect for the individual, likewise difficult to have in a complex "mass age." Then, we

must avoid the tendency to seek quick, "practical" solutions for children's behavior problems. The prescribed remedies are often a literal attack on present symptoms without due attention to underlying causes and meanings. We can get much better results if we will look more to dealing with causes. The task may be considerably simplified by differentiating carefully between pathology and behavior that is annoying but "normal."

Physicians are familiar with the crucial areas of any child's "living experience" where normally there is a significant interaction of physical and psychological factors—areas such as feeding, weaning, and elimination. By helping parents see the "normal" side of "problems" in these areas, physicians and nurses can help prevent many serious difficulties.

One of the most promising instruments for prevention that can be used by parents, teachers, social workers, nurses, physicians, and others is the development of adult insight into the child's view of the world and life. This priceless understanding can come from deliberate, frequent exercise in wondering, without blaming: How does Susie feel about this? What does it mean to little Freddie? Does Mary see her behavior the same way mother does? What lies behind this child's conduct? What needs does he have? How are they being met? This is an approach to good communication with children, which is the only avenue through which healthy personalities may be reared.—A. B. ABRAMOVITZ, *Supervisor, Clinical Psychology, Division of Child Guidance.*

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3. Jensen, Howard E.: Mental health: a local public-health responsibility, Ment. Hyg. 37:530–544 (Oct.) 1953.

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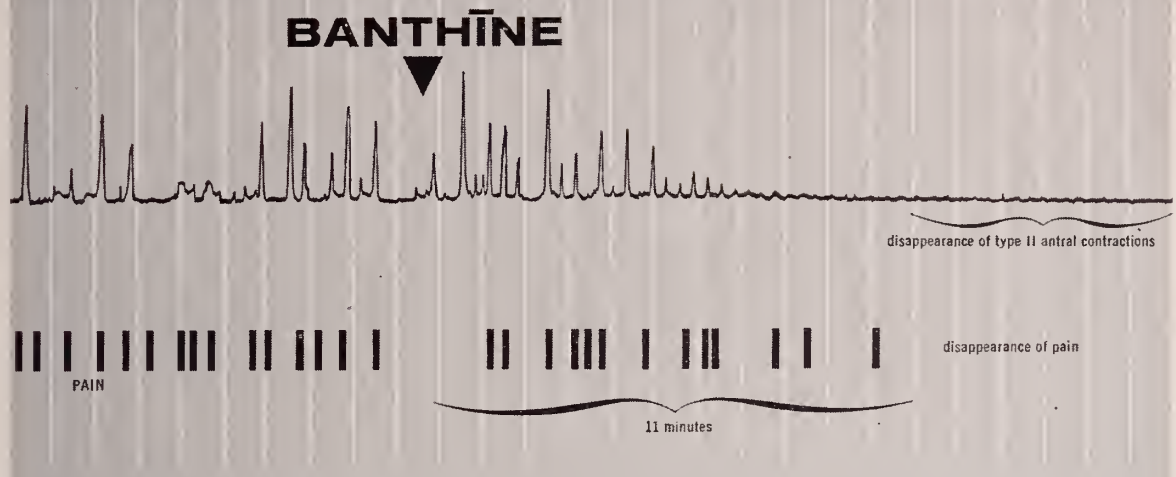

Effect of 100 mg. of Banthīne administered orally on antral gastric motility and duodenal ulcer pain.

Hightower, N. C., Jr., and Gambill, E. E.: Gastroenterology 23:244 (Feb.) 1953.

Hypermotility and Hyperacidity

A recent evaluation of anticholinergic therapy in peptic ulcer emphasizes the fact that now the profession has at its disposal agents that are "effective in reducing both secretory and motor activity of the stomach."

The effect on motor activity is generally more pronounced and less variable than on secretion; pain relief is usually prompt; a high degree of effectiveness is noted in ambulatory ulcer patients.

Ruffin, J. M.; Texter, E. C., Jr.; Carter, D. D., and Baylin, G. J.: J.A.M.A. 153:1159 (Nov. 28) 1953.

With its proved anticholinergic effectiveness, Banthine has been found extremely useful in the medical management of active peptic ulcer, whether duodenal, gastric or marginal.

The immediate increase in subjective well-being and the simplicity of the Banthine regimen assures patient cooperation. The recommended initial therapeutic dose is 50 or 100 mg. (one or two tablets) every six hours around the clock, with subsequent individual adjustment. The usual measures of diet regulation, rest and relaxation should be followed.

Banthine is effective in other conditions caused by excess parasympathetic stimulation. These include hypertrophic gastritis, acute and chronic pancreatitis, biliary dyskinesia and hyperhidrosis. Banthine is contraindicated in the presence of glaucoma and should be used with caution in the presence of severe cardiac disease or prostatic hypertrophy.

Banthine bromide (brand of methantheline bromide) is supplied in scored tablets of 50 mg. and in ampuls of 50 mg. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

SEARLE

. . . . THE PRESIDENT'S PAGE . . . .

IN THE early part of the winter just closed, the President of the United States, Dwight D. Eisenhower, promulgated what he termed "Safe Driving Day." On that day there was a nationwide attempt on the part of everyone who drove a motor vehicle to drive safely and abolish, at least for one day, the accidents on our highways.

The result was an appreciable decrease in accidents. It was made clear that if they tried, the American people could improve safety on the highways to a considerable extent and reduce markedly the high toll of death and injury.

Last autumn the Governor of Wisconsin, Walter Kohler, organized a Conference on Traffic Safety at which people from all walks of life came together to discuss this vital question. The State Medical Society was represented at this meeting.

We of the medical profession have a more than usual interest in highway accidents. It is an everyday occurrence for us to see the emergency rooms of our hospitals filled with injured and dying people as a result of them. No one is more familiar with the problem than the doctor who tries to patch up these unfortunate victims. Traffic safety is something in which we are vitally interested.

What is it that seems to transform some people, when they get behind the steering wheel of an automobile, from kind, decent, polite citizens to selfish, impatient, chance-taking potential killers? The most courteous individual in his home or office may change into an automobile driver who transgresses the rights of pedestrians and consistently breaks all speed and traffic rules. Why do the rules of politeness cease to operate when one gets into his high-powered motor car?

E. Clark Woodward, chairman of the Governor's Committee on Highway Safety, is aiming at a three-point program of education, engineering, and enforcement to meet this problem. He wants, first, more stringent regulations regarding the licensing of drivers to eliminate the irresponsible and incompetent; second, the modernizing of all our highways; and third, a considerable enlargement of the state traffic patrol. All of these steps seem to be necessary if we are to make any headway in abolishing this toll of death, injury, and property damage. A fourth point might relate to the installation and use of safety belts in all automobiles and the incorporation of more effective personal safety features in the design and construction of modern automobiles. But just as important, it seems to me, is the observance of the ordinary rules of politeness and courtesy. When we are driving our motor vehicles, let us always remember the Golden Rule.

Arthur J. McCary M.D.

THE MEDICAL FORUM

TELL STATE PLAN FOR POLIO VACCINE PROGRAM

Dr. Griffith

Name Fourth Society Delegate to AMA

Madison, Feb. 28. — Dr. J. C. Griffith, Milwaukee, was elected to be the State Medical Society's fourth delegate to the American Medical Association by the Society's Council at its February meeting in Milwaukee.

Dr. R. E. Galasinski, Milwaukee, will serve as the fourth alternate delegate. Dr. E. L. Bernhart, Milwaukee, president-elect of the Society, was named to fill the post of alternate delegate formerly held by Dr. Griffith.

Dr. Bernhart's appointment is designed to establish the tradition of having the Society's president-elect serve as an alternate delegate for the group to the American Medical Association.

Use TV to Report Polio Vaccine Results

A closed-circuit television broadcast will announce the results of the polio vaccine trials of 1954, now being evaluated at the Polio Vaccine Evaluation Center at the University of Michigan, according to information released by the National Foundation for Infantile Paralysis.

The telecast will be nationwide, presented through state and county medical societies in the areas where the TV outlets are located. Date of the broadcast will depend upon the completion of the vaccine report. It is expected to be ready by early April.

Madison, Mar. 1. — Distribution of the Salk polio vaccine in Wisconsin will be handled in 1955 by the State Health Officer through the district offices of the State Board of Health and local public health services.

Announcement of the details of the distribution plan was made by Dr. Carl N. Neupert, State Health Officer, after the program had been approved by the Blood Bank Committee of the State Medical Society, the State Department of Public Instruction, and the Wisconsin Chapters of the National Foundation for Infantile Paralysis.

Dr. Neupert emphasized that distribution will be made only if the vaccine has been found effective in the 1954 vaccine field trials now being evaluated by the Polio Vaccine Evaluation Center at the University of Michigan, and is subsequently licensed by the federal government. The report is expected in early April.

LIST VACCINE PRIORITIES

The National Foundation will make 9,000,000 immunizing doses of the vaccine available without cost on the following priority basis:

1. All children at present enrolled in the first and second grades.
2. All children who participated in the vaccine field trials in 1954, but who did not receive vaccine (this includes all fourth grade children in the field trial areas, and some third grade children in those areas). Wisconsin field trials were held in Dane, Eau Claire, Fond du Lac, Kenosha, La Crosse. Milwaukee, Rock, and Wood counties in 1954.

If the vaccine is found effective and is licensed, manufacturers will make an equal supply available for purchase by physicians and others.

Working with the state and district health officers in administering the vaccine program will be county nursing services, city public health nursing services, city health departments, and city-county health departments.

(Continued on page 34)

ELECT DR. PAUL MASON TO SERVE ON NATIONAL BLUE SHIELD COMMISSION

Madison, Feb. 10.—Dr. Paul B. Mason, Sheboygan, has been elected to the Commission of the Blue Shield Medical Care Plans, Inc., to represent the 10th Blue Shield District.

Dr. Mason will represent the Blue Shield plans in the states of Wisconsin, Minnesota, Iowa, Nebraska, and South Dakota. His term on the National Blue Shield Commission begins immediately following the next annual meeting of the Blue Shield group in Chicago, March 20–24.

He succeeds Dr. E. M. Dessloch, Prairie du Chien. Also serving as a Blue Shield commissioner from the 10th district is Mr. Woodrow H. Sherin, executive director, Iowa Medical Service.

Dr. Mason was elected at a meeting of Blue Shield plan representatives in St. Paul on January 30. Physicians who represented Wisconsin Blue Shield plans at the meeting were Drs. Mason and Dessloch; J. W. Fons, Milwaukee; and R. M. Moore, Frederic.

Dr. Mason is a member of the Commission on Prepaid Plans of the State Medical Society, the agency which is charged with the operation of Wisconsin Physicians Service and other insurance activities of the Society.

He has served as a delegate to the State Medical Society for nine years. In addition to his work on the Commission, he has been a member of the Blood Bank Committee of the Society.

MEDICAL STUDENTS SHOW GROWTH OF ORGANIZATION AT CONVENTION

Milwaukee, Feb. 15.—"Many of the problems of modern medicine might well be nonexistent today had an organization such as SAMA existed twenty or so years ago." This statement was made by Fred G. Sehring, Jr., Milwaukee, in a report from the Student American Medical Association chapter at Marquette University School of Medicine.

Mr. Sehring represented his chapter at the SAMA convention in Chicago last year. He served as chairman of the credentials committee of the convention.

The State Medical Society annually provides grants of $100 each to the two Wisconsin chapters of the Student American Medical Association to help pay expenses for delegates attending the SAMA convention. The chapter at the University of Wisconsin Medical School is known as the Wisconsin Student Medical Association (WISMA).

Mr. Sehring

SPONSORS INSURANCE PROGRAM

Two Wisconsin medical students, one each from the Wisconsin and Marquette chapters, are serving as members of the Executive Council of SAMA. Eugene Weston of Madison and David LaFond of Milwaukee were elected as executive councilors at the convention.

In his report on the activities of the Student American Medical Association, Mr. Sehring indicated that one of the major activities of the growing organization is the sponsorship of a life insurance program for medical students. The program, known as SAMA Life, is being widely accepted.

In all, 58 delegates from SAMA chapters attended the convention, according to Mr. Sehring's report. During the meeting, the delegates passed resolutions urging:

1. Passage of legislation where needed to insure medical centers of an adequate supply of dogs by the method of requisition of animals which, unwanted and unclaimed, would otherwise be destroyed.

2. Opposition to a program of the Federal Government which would distribute scholarships on a year-for-year basis to medical students.

3. Changes in present legislation on medical care for veterans so that the responsibility for the health care of veterans with non-service-connected disabilities would revert to the individual or, in the case of indigency, to the state or local government.

4. A SAMA survey to ascertain opinions on the establishment of a minimum standard of payment per month above and beyond the services of room, board and laundry for interns and residents.

5. Establishment in the United States of a central repository for the educational records of all the physicians in the world.

Mr. Sehring reported that the SAMA convention was a "huge success." He believes it has showed the ability of medical students to think and seriously debate the problems which face medicine today "with an insight that might be quite unexpected from them."

AMA Issues Reprint of Report on Insecticides

Madison, Feb. 15.—Reprints are now available of the report titled, "Abuse of Insecticide Fumigating Devices," published by the Committee on Pesticides of the American Medical Association's Council on Pharmacy and Chemistry.

The report was reprinted from the October 9, 1954, issue of *The Journal of the American Medical Association.* It was prepared because of indications that many manufacturers of insecticide fumigating devices were continuing to make untrue advertising claims which fostered misuse of the poisons involved.

Physicians may obtain copies of the reprint of this report, free of charge, by writing the State Medical Society, Box 1109, Madison 1, Wisconsin.

County Societies Can Request Insurance Talks

Madison, Mar. 7.—The Wisconsin State Association of Accident and Health Underwriters is making available a number of speakers for county medical society meetings.

The speakers will discuss major medical expense coverage, the latest development in the health insurance field.

The talks will cover the reasons for the development of the new coverage, the various types of plans available, the number of persons covered in Wisconsin, and the impact of this new protection on the physician.

Medical societies who wish to obtain these speakers are requested to write to: Mr. Charles H. Gilbert, The Wisconsin State Association of Accident and Health Underwriters, 4114 Buckeye Road, Madison 4, Wisconsin, or to the office of the State Medical Society.

Report Progress in TV For Medical Education

Chicago, Feb. 5.—Dr. John Z. Bowers, present dean of the University of Utah School of Medicine, reports success in the use of television for postgraduate medical education.

Speaking at the Congress on Medical Education and Licensure, held in Chicago in February, Dr. Bowers described the four clinics presented by the University over an open channel Salt Lake City station as the least expensive form of postgraduate medical education the school had ever attempted.

Studies by the television station indicated that the programs, telecast from 7 to 8 a.m., received little non-medical "kibitzing."

During the conference, a demonstration of "scrambled image" television was presented. While such scrambling provides one solution to the problem of maintaining "medical security" for open circuit programs, there is some question of whether existing FCC regulations would allow it to be used.

Discussions were also held on the use of black and white versus color television. It was pointed out that while color is an addition to some types of presentations, often the quality of the image is poor and the color "over-done."

RURAL HEALTH MEET DRAWS WIDE STATE PARTICIPATION

Madison, Feb. 28.—Wisconsin's physicians demonstrated their vital interest in problems of rural health by joining with representatives of farm, service, and community organizations in the state to set record attendance figures at the National Conference on Rural Health, sponsored by the American Medical Association's Council on Rural Health, from February 24 to 26 in Milwaukee.

STRESS NEED FOR COOPERATION

Representatives of county, state, and specialty medical groups heard the need for continued cooperation between farm and medical personnel emphasized throughout the 3-day session of lectures and discussions, held at the Schroeder Hotel. Sounding the keynote of the conference, "Looking Both Ways," at the opening session, Dr. F. S. Crockett, Lafayette, Ind., said that what the family doctor wants is "a voluntary working partnership with the people, especially rural people."

He added that "everyone can be taught the essentials of healthful living" as well as how to work together "to solve those problems where the group is more effective." Dr. Crockett is chairman of the AMA Council on Rural Health.

RECOMMEND CLINIC-HOSPITALS

Two physicians recommended the use of clinic-type hospitals as one solution to the problem of providing adequate medical facilities and care to people in rural areas, during the panel discussion on "Using Medical Care and Resources." Dr. Wyatt Norvell, New Castle, Ky., chairman of the Kentucky Medical Association's committee on rural health, pointed out that providing medical resources—the training of good physicians—is the job of the medical profession, while providing adequate health resources is the job of everyone. "The very backbone of our life as I see it from the medical standpoint is the family physician," he said. "But you're not going to find the family doctor at every crossroads," he pointed out, because modern transportation makes it unnecessary. He added that a hospital at every crossroads is also unnecessary.

"The answer to our medical resource work is the use of clinics," he stated and cited indifference, fatalism, and the acceptance of "spoonfed help" from a centralized government as major obstacles.

Clinic-type hospitals of from 25 to 50 beds, serving communities of 10,000 to 15,000, were also urged by Dr. Robert N. Barr, Minneapolis, executive officer of the Minnesota Department of Health. He added that high school students should be educated to scan the 158 types of careers open in the health and medical field as an answer to the need for personnel.

Other conference discussions covered farm and home accidents, community recreation projects which produce by-products of better community health, and various state projects designed to meet specific local problems.

It was pointed out that most farm accidents are caused by carelessness and the same is true of industrial, highway, and home accidents. Since much of this carelessness arises from physical and emotional upsets, it was suggested that safety programs be aimed at increasing personal well-being as well as emphasizing safety warnings.

Gaining public acceptance for community health projects was discussed in a session devoted to special state health programs. Joseph Banach, Marinette, safety director for the Ansul Chemical Company, told of the emergency rescue squad organized and operated by the company's employees which failed to gain public cooperation until it proved its worth in a serious accident in Marinette several years ago.

Also described were a weight reduction program in Illinois, enlisting the aid of local health and medical personnel, and an experimental project in Tennessee in which organized labor and medicine joined forces to provide medical care for people in isolated rural areas.

400 HEAR PRESIDENT ON AMA "VIDECLINIC"

Milwaukee, Feb. 10.—Over 400 Wisconsin physicians heard a television talk by President Eisenhower when they gathered at Milwaukee's Pfister Hotel on February 9 for a nationwide closed-circuit medical telecast on coronary artery disease.

Speaking for a few minutes in connection with "Videclinic," a closed-circuit "medical journal of the air" sent to 32 cities, the President said that "we must strengthen and support those agencies of the government which are concerned with the problems of national health," but that "the role of government in these matters must always be secondary and supplementary."

The Medical Society of Milwaukee County acted as host to the physicians who attended the telecast which was sponsored by Smith, Kline & French Laboratories in cooperation with the American Medical Association.

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Participating in health examinations discussion at School Health Conference are, left to right: Dr. Porter Blanchard, Cedarburg; W. R. Dunwiddie, Port Washington schools' superintendent; Fred Holt, West Bend schools' superintendent, moderator; Harry Olson, Oconomowoc schools' superintendent, recorder; Dr. A. H. Heidner, West Bend; Kay Kuehlthau, R. N., Elkhorn; T. E. Ryan, D. D. S., Waukesha.

Record Crowd Attends Milwaukee Conference on School Health

Milwaukee, Feb. 11.—Nearly 800 persons, including 40 physicians, attended the school health conference in Milwaukee on February 10 under the sponsorship of the State Medical Society and the Wisconsin School Health Council.

The huge audience listened intently to a two-hour program on "The Integrated Physical and Emotional Growth of Children," led by Dr. E. S. Gordon and Dr. Thomas Lorenz, both of the University of Wisconsin Medical School. J. Martin Klotsche, Ph.D., president of Wisconsin State College, Milwaukee, praised the State Medical Society and the School Health Council for "approaching the school health problem in a way that exemplifies the true spirit of a democracy."

URGE USING COMMON SENSE

Dr. Gordon detailed the phenomenon of growth and development of children and concluded that "parenthood is too often looked upon as a God-given attribute that is accepted with a let-nature-take-its-course attitude." Dr. Gordon pointed out that the job of being parents requires real thinking and planning if it is to be accomplished successfully.

Dr. Lorenz made a plea for abandonment of the thinking that children are going to the dogs. He said that if parents would do less reading on child rearing and "use more common sense," they would do a better job.

"If parents would use some common sense, a great deal of love, and a lot of respect, they would do a first-class job."

Six panel discussions, throughout the afternoon, were well-attended and elicited good participation.

Plan European Tour For Wisconsin M.D.'s At World Medical Meet

Madison, Mar. 4.—A Wisconsin medical tour for the 1955 World Medical Association meeting in Vienna, September 20 to 26, is being planned for physicians, their families and friends.

Participants may arrange transportation to Europe by steamer or air, leaving New York on August 24 or August 28 and leaving England for the return trip on October 6.

The European land tour will cover England, France, Switzerland, Italy, Austria, Germany, and Holland, with visits to London, Paris, Lucerne, Florence, Rome, Venice, Salzburg, Vienna, Munich, Heidelberg, Wiesbaden, and Amsterdam. Five-day extension trips to Ireland or the Scandinavian countries are also available.

The tour will be conducted by the Polytechnic Touring Association, Ltd., London, England, one of Europe's largest independent travel organizations. The tour will allow slightly more than four full days at the World Medical Association meeting in Vienna, September 22 to 25. The meeting annually attracts an increasing number of physicians from all parts of the world. The American Medical Association has been particularly instrumental in the development of the meeting.

For additional information about the tour, write to Wisconsin Medical Tour, P. O. Box 774, Madison, Wisconsin.

DISCUSS FUTURE OF INTERN TRAINING

Chicago, Feb. 8.—The internship problem is one for the entire profession to solve, according to Dr. William B. Hildebrand, Menasha, president of the American Academy of General Practice.

In a talk on the future status of the internship, presented during the annual Congress on Medical Education and Licensure in Chicago in February, Dr. Hildebrand emphasized that the internship should be developed to provide future GP's with the greatest possible educational opportunities, since they will probably continue to dispense much of the country's medical care as they do today.

Dr. Hildebrand outlined two possible plans, both based on the theory that two years of supervised hospital study are necessary for any type of practice.

The first plan would place fourth year students as "junior interns" in teaching hospitals on a full-time basis. The student would be rotated through the major fields and would "follow through" on patients; however, a smaller patient load would allow him to attend classes daily for the subjects usually taught in the fourth year.

The fifth year would be a "senior internship" with increased responsibilities and a program of study devised to fit the student for his ultimate objective.

The second plan suggested by Dr. Hildebrand would also establish a 2-year internship. It would continue the existing first year and would provide a second year internship or residency which would give additional training in disease as a single discipline.

For students wishing to specialize, specialty boards might credit this year as the first year of residency. For general practitioners, he said, this year could be recognized as a residency, with a suitable certificate presented.

SOCIETY CLARIFIES LAW ON PHYSICAL THERAPISTS

The law which requires that physical therapists be certified and that they practice under the prescription and direct supervision of a physician is intended to limit the physical therapist to the technical field in which he is trained.

The State Medical Society emphasizes this fact in answer to a number of requests for interpretation and clarification of the physical therapy law which was passed as part of the revised medical practice act in 1953.

According to the purpose and intent of the law, the Society states, the physical therapist, and the masseur before him, is a technician. He is not trained in diagnosis, physiology, or pathology, nor is it intended that he be.

The law imposes two requirements upon the physical therapist. The first is that he be certified and the law sets forth minimum qualifications as a prerequisite to certification. The second requirement is that he practice under the prescription and direct supervision of a physician, hence providing the professional judgement, skill, and training possessed by the licensed physician and surgeon.

MUST MEET BOTH REQUIREMENTS

The question has been raised as to whether a physical therapist must meet both requirements; that is, if he holds a certificate of registration, must he also practice under the prescription and supervision of a physician. The Society explains that, under familiar construction of the law, if a person represents himself as a physical therapist, then he must meet both requirements.

However, the Society adds, this does not mean that a physician may not delegate to an assistant purely ministerial duties in the physical therapy field. Although a physician will not delegate to an unqualified individual the exercise of professional judgment, he would be extremely handicapped were he prohibited by some unrealistic rule which forbade him delegating a ministerial task.

Thus, the Society says, in the physical therapy field, there would appear to be no reason why a physician should not delegate to an assistant the task of timing a patient's exposure to infra-red rays or attending him during a sitz bath. In that situation, the individual assistant would be practicing under the prescription and the supervision of a physician. But, emphasizes the Society, if the assistant did not hold a certificate of registration in physical therapy, he could not represent himself as a physical therapist or use any titles indicating that certification.

The portion of the statutes which governs the physical therapist is Section 147.185, Wisconsin Statutes, 1953. The text of this Section is printed on page 24 of the January, 1955, issue of *The Wisconsin Medical Journal*, under the article, "The Revised Medical Practice Act," which begins on page 20 of that issue.

AMA Replaces Seal Acceptance Program

Chicago, Feb. 19.—The American Medical Association has discontinued its "seal acceptance" program in order to provide more information faster on new advances in medicine.

An editorial in the February 19 issue of *The Journal of the American Medical Association*, explained that: "To meet the demand caused by the tremendously and broadly expanding horizon in diagnostic, curative, and preventive medicine is a problem of no small dimensions. Therefore, the Board of Trustees and the councils have decided to spend more time on this important phase of their work and to increase this work to match the need."

Under the new program, the councils will issue prompt and frequent reports on what is new in the various phases of medicine; they will periodically review the status of agents and techniques; and they will develop basic standards for classes of goods. In addition, the editorial said, "They will undertake educational efforts" for utilization of the information.

Fourth Conference on Children and Youth To Be Held in April

Madison, Mar. 4.—The State Medical Society has accepted the invitation of Governor Walter J. Kohler to be a sponsoring organization for the Fourth Governor's Conference on Children and Youth which he has called for April 14 and 15 at the Memorial Union in Madison.

Dr. H. Kent Tenney, Madison, past president of the Society, is a member of the program committee for the meeting, which will be based on the theme of "Building Family Strength in a Changing World." He is vice-chairman of the Wisconsin Committee on Children and Youth which plans the biennial Conferences.

The theme of the 1955 meeting will be presented through general sessions, section meetings, plays, films, and dramatizations. Participation by youth and adults, and professional and lay citizens will provide a teamwork approach to the joint responsibility of strengthening family living. Over 1,600 delegates attended the Third Governor's Conference in 1953.

Speakers, in addition to Gov. Kohler, will include Rev. E. S. Hjortland, pastor, Central Lutheran Church, Minneapolis; and Wakelin McNeel, general chairman of the Conference. Section meetings will feature " Do It Yourself—a Family and Community Tool Kit."

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available on request.

Physicians Urged to Participate in Wisconsin Public Health Council

Madison, Mar. 1.—A special invitation is being issued to all Wisconsin physicians to become individual members of the recently incorporated Wisconsin Public Health Council.

The State Medical Society is a sponsoring organization of the council, having become a charter member of the reorganized group. The council held its first annual meeting since its incorporation in Milwaukee on February 25.

During the meeting, program plans for the coming year were discussed and new directors and officers named. Major projects now under study by the council are migrant worker camp conditions in Wisconsin and recruitment of health personnel.

Five new members elected to the Board of Directors are: Mrs. Alice Sanders, Health Division Secretary, Milwaukee Community Welfare Council, and Grant Larned, executive secretary of the Wisconsin Heart Association, both of Milwaukee; Mrs. Roy Nelson, Kaukauna, vice-president of the Outagamie County Health Council; Mrs. Monroe Tubbs, Cross Plains, president of the Dane County Association of Health Councils; and Mrs. J. A. Riegel, St. Croix Falls, Polk County Health Council.

Miss Edith Bangham, Madison, was re-elected president by the board, and Dr. Allan Filek, Madison, will continue as treasurer. A. F. Wileden, Madison, and R. A. Mason, D. D. S., Milwaukee, were named first and second vice-president respectively. Other directors continuing on the board include: Deane Bascom, West Bend; C. H. Crownhart, Madison; Palmer Daugs, Lake Mills; C. W. Kammeier, Milwaukee; Dr. M. W. Stuessy, Brodhead; and Mrs. Caryl Vigdahl, Viroqua.

Reorganized to broaden its membership basis and aims, the council acts as a fact-finding, educational agency designed to encourage better health throughout the state.

The purposes of the corporation are the following:

1. **To stimulate citizen interest in public health in Wisconsin.**
2. **To encourage the development of sound public health programs and practices throughout the state.**
3. **To further the cooperation and integration of the voluntary and official agencies working in the field of public health.**
4. **To promote the formation of and assist in the development of local councils.**
5. **To stimulate through education and organization, increased citizen interest and participation in programs of sanitation, disease control, and health advancement.**

Individual membership dues in the council are $1 per year. Application may be made to the Wisconsin Public Health Council, Box 1109, Madison 1, Wisconsin.

Establish 11 Counties As First Disaster Area For Civilian Defense

Madison, Feb. 14.—Eleven counties in Southeastern Wisconsin have been formally designated as "Disaster Region No. 1" by Major General Ralph J. Olson, State Director of Civil Defense.

The counties include Kenosha, Racine, Milwaukee, Ozaukee, Washington, Waukesha, Walworth, Jefferson, Dodge, Sheboygan, and Fond du Lac. Brigadier General Harry G. Williams of the Adjutant General's office, was named coordinator of the area.

The move was made to provide a means of coordinating state, county, and local civil defense activities for evacuation of the most heavily industrialized and populated area of the state. According to the Civil Defense office, this will be the initial phase in developing a statewide evacuation plan.

Plans are now being formulated for handling the plan's mechanics.

Outline Approved For School Vision Screening Program

Madison, Mar. 7.—An outline to facilitate the development of a local school vision screening program has been approved by the Council of the State Medical Society.

The purpose of the guide is to outline the organization of local programs to detect significant visual defects among school children.

Jointly prepared by the Section on Ophthalmology and Otolaryngology of the State Medical Society and the Wisconsin Optometric Association, the plan was approved by the Commission on State Departments before going to the Council.

The outline suggests that any local school vision screening program be started with a planning committee which includes a public health nurse, health officer, representatives of the county medical society and the area optometric society, and persons representing schools and parents.

A continuing professional advisory committee to select the tests, establish standards, and evaluate the program as it continues should include a public health nurse, ophthalmologist, and optometrist.

Annual visual screening of school children is recommended. As a minimum program, grades 1, 4, and 7, as well as all new pupils, should be screened annually. In addition, children observed by teachers as presenting possible visual defects should be checked periodically.

The selection of the type of vision test is left to the professional advisory committee.

It is recommended that the director of the program, who should be named by the planning committee, not be an optometrist or a physician. Teachers or volunteer lay women properly trained can administer the initial vision screening tests. Public health nurses or specially trained and proficient lay persons should recheck children who fail initial tests.

All children having unsatisfactory vision tests, as well as those having significant visible eyelid or ocular defects, should be referred for further eye examination and refraction to an eye doctor of their choice.

It is suggested that, if special funds are needed, they might be sought from service clubs and other private organizations. Such funds might be used for the purchase of screening test equipment; to offset clerical, stationery and mailing costs; and to provide financial aid for professional fees and glasses in needy cases.

SMS HEADQUARTERS BUILDING NEARS COMPLETION

Madison, Feb. 21.—Almost all heavy construction in the State Medical Society's new headquarters building has been completed, according to the society's architect and contractor.

Ground was broken for the new building last May. The 2-story glass and red brick structure is expected to be ready for occupancy about June, 1955.

Situated on the southern edge of Madison, on the shore of Lake Monona, the new Society office is planned to relieve the crowded working conditions in the Society's present office at 704 East Gorham Street on Lake Mendota.

The growth of the Blue Shield program, including an extensive installation of electronic equipment which is used in other Society functions as well, and increased activities assigned to the state office by the House of Delegates have been primarily responsible for the need for additional space.

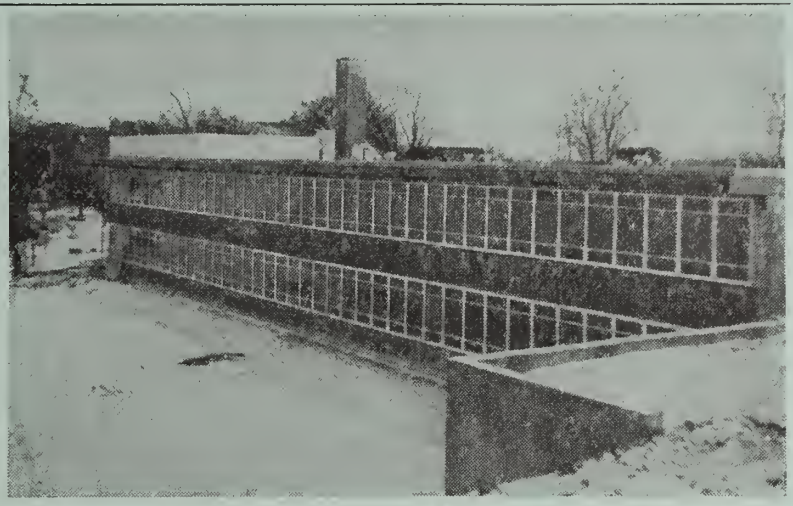
The new building is of modern design and is planned for the most effective utilization of office space, air, and light. The exterior is about 90 per cent complete. Major heavy construction on the inside has been done and work is now going ahead on finishing floors, tiling, painting, installation of doors, and similar details.

The ground floor of the building will contain a large room for IBM equipment, a mailing and machine room for such services as mimeographing and folding, the Claims Department of Wisconsin Physicians Service, and a kitchen and dining room for employees and State Medical Society committee meetings and special functions. The dining room has cafeteria features and can be divided by folding doors, into three private dining areas.

The top floor, which will be the only floor visible from the street side, has approximately 2,000 square feet of meeting space which can also be divided into three separate smaller rooms by folding partitions. This floor houses the reception area, secretary's office, a variety of other administrative offices, and centralized filing area.

A sub-basement will contain the heating equipment for the building.

The building was designed by Weiler and Strang and Associates, architects. The general contractor is Anthony Grignano.



Lakeside view of new Society building. Lower floor houses Blue Shield offices, room for electronic records equipment, and dining room. Top floor houses administrative offices and council room.

A street view of the new State Medical Society headquarters building. Exterior work is about 90 per cent complete and heavy interior construction is done. Finishing work is just starting on the interior.

VISITORS WELCOME

Any physicians who are in the Madison area and have a few moments to spare are invited to visit the site of the new Society headquarters and view progress on the building. The address is 338 East Lakeside Street. This street branches off South Park Street in Madison just a few blocks northwest of the junction of City Highway 12 with Park Street.

Governor Kohler Urges Stronger Civil Defense

Madison, Feb. 1.—In his message to the Legislature, Governor Walter J. Kohler urged that "serious attention" be given to a proposal for improving civil defense statutes.

He pointed out that the need for an adequate civil defense program has assumed "major significance." He said, "Military technology has brought within the realm of possibility the destruction of any one of Wisconsin's major cities by enemy action."

The proposal would authorize the state director of civil defense to prepare a state evacuation plan. Approved by the legislative council, the bill "contemplates the maintenance of a civil defense system by the local units of government," and provides for expanded police powers in emergencies.

1955 STATE HIGHWAY MAPS GIVE FIRST AID RULES

Auto accident victims in Wisconsin from now on won't have to look very far for immediate first aid suggestions, for their 1955 state highway maps will be carrying a list of the most important rules.

In addition, the map will tell them at a glance the location of the nearest general hospital.

The maps, which will become available about April, provide the answer to a long-felt need for positive measures to reduce auto injury and death rates through education of the public in proper accident care.

The new maps will show cities with general hospitals by red dots in front of the city names on the "Index of Incorporated Cities and Villages." A section nearby will carry several paragraphs of material titled, "First Aid Suggestions."

Addition of the material to the maps was the result of joint efforts by the State Medical Society, the State Board of Health, and the State Highway Commission which cooperated in preparing the copy and incorporating it into the 1955 issue.

The following material is included in the section under "First Aid Suggestions."

"When persons are injured in an automobile accident, the police should be notified at once and requested to obtain medical aid if it seems necessary.

"In event of illness or accident while travelling, emergency medical aid can be obtained most quickly by calling or going to a general hospital in one of the cities marked on the index to incorporated cities and villages.

"Every automobile should carry a first aid kit. It should always contain several yards of sterile gauze and bandages.

"Victims of automobile accidents should be moved only by qualified persons such as physicians, police officers, firemen, ambulance personnel, or others trained in the handling of injured persons. Judgement must be used, of course, when the injured person is in danger of losing his life or being further injured if he is not moved.

"Until medical aid arrives, you should loosen the victim's clothing, especially around the neck. Stem the flow of serious bleeding with pressure dressings—wads of gauze or clean cloth held firmly against the wound."

DOCTORS BEGIN USE OF PHONE BUREAU

Watertown, Feb. 10.—Several Watertown physicians have joined together to employ a telephone service bureau which will enable their patients to locate them more quickly. Patients are instructed to call the bureau's number when the doctor cannot be reached at either his home or office.

The bureau will not act as an emergency call system. However, when a patient cannot reach a doctor who is using the bureau, at either his residence or his office, the service will contact the doctor or his designated alternate or relay a message left by the doctor.

Emergency cases in Watertown are handled either by the family doctor or by a panel of physicians in cooperation with St. Mary's Hospital.

—Kenosha Evening News Photo

Kenosha County Medical Society honors Kenosha police officer, Norman LeWand, center, for outstanding contribution to public health and safety. Dr. D. N. Goldstein, left, and Dr. Leif Lokvam, present official citation and $100 savings bond from Society for LeWand's rescue of drowning man on Christmas Eve.

POLIO PROGRAM . . .

(Continued from page 27)

In counties with no public health nursing services, the county medical society will be responsible for administering the program. The county society may designate a program director to organize and conduct the program as recommended by the State Health Officer. In other counties, the county medical society will be asked to cooperate with the program, particularly in encouraging physician participation in immunizing clinics.

Immunization clinics will be held wherever possible in the schools. Local and county health services, or county medical society program directors, will be responsible for securing and maintaining the necessary clinic and vaccine supplies and records, securing volunteer help for the clinics, and arranging the hours and days for clinics with medical and school personnel.

School authorities will arrange rosters, by schools, of all children eligible for vaccination and will distribute parent informational and educational material together with parent request slips. Written parental request forms will be submitted for each child vaccinated. In addition, school authorities will arrange for parent, teacher, nurse, and physician meetings when necessary to explain the immunization program.

District health offices and the State Department of Public Instruction will act as centralizing agencies for administation of the program and will solicit the cooperation of various voluntary agencies, such as local polio chapter groups, county and local school authorities, and county medical societies.

Facts about

"THE DOCTORS' PLAN"

THE BLUE SHIELD PLAN
OF THE
STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON PREPAID PLANS

An Idea Isn't Everything

Back about 1946, many physicians helped to jell the Blue Shield idea in Wisconsin. The idea wasn't brand new. It was an adaptation of another, but with a practical application to this state.

The basic idea in Blue Shield was that it be "The Doctors' Plan." This idea developed because physicians more than anyone else know, out of their own experience, the necessities of the people for health insurance. Equally important, the physicians know the type of coverage and the kind of benefits most necessary for adequate, yet economical, protection. The idea implies that it is the doctor's plan for his patients.

The idea of a doctor's plan suggests, at least, that the doctor will help to promote it. Since it is his plan for his patients, it should be to his interest to see that as many people are covered by it as are within the range of his care and influence. This does not imply that he be a salesman except that the best salesman for any product or service is a satisfied consumer. If the physician can assist his patients in the more satisfactory handling of their economic problems as related to medical care, he will have fulfilled another part of his responsibility as family physician and counselor.

The Blue Shield idea has now matured to the point where its practical application should be more apparent than ever to the physician.

Today, the Blue Shield Plan in Wisconsin offers an outstanding non-group policy. This means that the physician can advise his patients that they as individuals and family units may be eligible to purchase the same broad types of benefits as are commonly available through industrial group plans.

Today, Blue Shield makes it possible for a group of under five employed persons to purchase the program on a payroll deduction basis with a single billing for all once a month.

The potentials of these two enrollment opportunities should be obvious. A high percentage of the businesses in Wisconsin are made up of groups of five or less individuals. Self-employed persons, whether they be businessmen or farmers, make up a truly significant portion of Wisconsin's population. They and their families need health insurance protection, and the physician has an unparalleled opportunity to influence their decision.

Blue Shield is a great idea. Only as it solves a realistic problem will its practicability be apparent. Whether Blue Shield can be a success depends on how well the idea is applied by those who created it. There is an old cliché in the business world which takes on real meaning for the physician who has the opportunity to support Blue Shield: "It is better to have a fair idea that is supported and is exhaustibly worked than the best idea in the world that nobody wants and that gets no follow-through."

For Information or Advice

Write • 704 E. GORHAM ST., MADISON, WIS. Phone • 6-3101 MADISON, WIS.

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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Volume 54 MARCH 1955 Number 3

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« « « EDITORIAL » » »

Capsule Magazines

What is responsible for the sudden increase in capsule magazines which give us nothing but abstracts of other literature, interspersed with voluminous advertising from the various pharmaceutical manufacturers, and which are sent to every doctor in the country gratis? This writer even gets a "medical digest" from one of the local pharmacists which purports to tell me what the newer drugs are, how they are to be used, and even which new books to read. In *The Journal of the American Medical Association*, "The Voice of Medicine," we find a pharmaceutical manufacturer taking 12 pages as an advertisement; but on superficial inspection, they look like part of the Journal. In one such advertisement, there is an article on the irritable colon, one on cardiac arrest, and some shorter "quick" articles on various medical subjects. Of course, it all ends up with a very subtle "plug" for the products of the manufacturer.

How long, oh Lord, is the long-suffering medical profession going to put up with this? The capsule magazines perform no function that is not adequately performed by the usual medical literature. Any M. D. who reads at least the AMA Journal and maybe one specialty journal keeps abreast of the literature and gets it from original sources rather than abstracts. The latter are quick and easy reading but totally unreliable because of their conciseness; and, human nature being what it is, they might also be slightly slanted in favor of the pharmaceutical houses which are paying the freight. None of us is too busy to do minimal reading, and none of us can afford not to do minimal reading. The "quick and easy" abstracts put out in the capsule magazines are relatively worthless and might well be relegated to the wastebasket on receipt.

The AMA is also open to great criticism for permitting in its Journal advertising which has the format of an academic treatise. The solution lies solely with us, and it is time we let the pharmaceutical companies know that their advertising would be much more acceptable without usurping the function of our legitimate journals.

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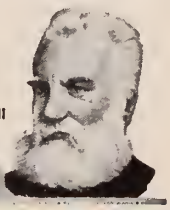

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Society Proceedings

Barron—Washburn—Sawyer—Burnett

Eighteen members of the Barron–Washburn–Sawyer–Burnett County Medical Society met on February 8 at the Elks Club, Rice Lake, to hear an address by Dr. A. O. Olson and Dr. J. H. Peterson of Duluth, Minnesota. They discussed "Eye Conditions Encountered in General Practice and Their Treatment."

Dr. James F. Maser of Rice Lake was appointed a delegate to the Tenth National Conference on Rural Health, held in Milwaukee, February 24–26.

Brown—Kewaunee—Door

Members of the Brown–Kewaunee–Door County Medical Society met on February 10 for dinner at 7:00 p.m. at the Elks Club, Green Bay. Dr. Marc H. Hollender, associate professor in psychiatry and chief of the Psychiatric Outpatient Department of the University of Illinois, spoke on "Psychological Problems of the Cancer Patient."

Dane

The Dane County Medical Society devoted its February 8 meeting to a discussion of grievance committees. The members assembled at the Madison Club, Madison, to hear a discussion by *Dr. Herman Wirka*, Madison, chairman of the county society's grievance committee and a member of the State Society's committee; Deputy Attorney General Stewart Honeck; and Mr. C. H. Crownhart, secretary of the State Medical Society.

Kenosha

The Kenosha County Medical Society held its regular monthly meeting at the Elks Club, Kenosha, on February 3. Forty-five members were present.

Dr. C. Morrison Schroeder, assistant clinical professor of surgery at Marquette University School of Medicine, Milwaukee, spoke on "Treatment of Trauma of the Abdomen."

At the business session, group insurance was discussed; and three committee members of the county board discussed plans for a new county home.

Manitowoc

Dr. Lee Van Antwerp, medical director of G. D. Searle and Company, Chicago, and president of the American Medical Writers Association, spoke to the members of the Manitowoc County Medical Society on February 17. His subject was "Anti-Cholinergic Drugs."

The meeting was held at the Hotel Manitowoc, Manitowoc, with dinner served at 6:00 p.m.

Outagamie

When the Outagamie County Medical Society met on January 20 at the Elks Club, Appleton, the meeting was devoted to a discussion of business matters.

Among the matters decided upon were the following: A copy of the minutes of each county meeting will be forwarded to all ill or retired members as a courtesy to keep them informed of the Society's activities. A donation of $25 was approved for aiding the National Society for Medical Research in its campaign against antivivisection. A program of monthly medical movies to be held the second Thursday of each month was approved. *Dr. Harold T. Gross*, Appleton, was approved as medical director of the Community Blood Bank being organized by the King's Daughters group of Appleton. Blood will be supplied to St. Elizabeth Hospital, Appleton, and the new Kaukauna Community Hospital.

Polk

Members of the Polk County Medical Society were guests of *Dr. D. A. Maas* of Webster at dinner at the Paradise Lodge, Balsam Lake, January 20. Seventeen members were present.

At the business meeting which followed, the society approved use of an x-ray bus for a survey of tuberculosis and a diabetic survey for adults to be done at the same time. Approval of diabetic survey of school children was withheld, as the members believed the incidence of the disease in that age group to be low. Plans for the mental health program held at Luck on February 4 and 5 were outlined.

Racine

Racine County Medical Society members met on January 20 at the Hob Nob, Racine, to hear a talk by *Dr. Carl Harper*, Madison, on "Significant Factors in Wisconsin Maternal Deaths in 1953."

Dr. Robert H. Lehner of Racine presented a report on the vision testing program conducted in Racine County grade schools in the fall of 1954.

Forty-eight members attended the meeting.

Richland

Two guest speakers addressed the members of the Richland County Medical Society on January 6 at its meeting at the Richland Hospital Library, Richland Center. *Dr. S. B. Harper* of Madison spoke on "The Use of Cortisone in Surgery," and *Dr. F. D. Bernard* of Madison discussed "Various Phases of Plastic Surgery."

Twelve members of the society were present.

Sheboygan

Forty-eight members of the Sheboygan County Medical Society met on January 27 at the Memorial Hospital, Sheboygan. *Dr. Friedrich Eigenberger* of Sheboygan spoke on a trip to Africa.

Dr. Joseph Kovacic of Sheboygan was appointed historian of the society.

Winnebago

The regular monthly dinner meeting of the Winnebago County Medical Society was held on February 3 at the Athearn Hotel, Oshkosh. *Dr. C. F. McDonald* of Milwaukee addressed the group.

Manitowoc County Chapter, Academy of General Practice

Dr. R. G. Strong, Manitowoc, was elected president of the Manitowoc Chapter of the American Academy of General Practice at a dinner meeting at the Hotel Manitowoc on January 26.

Other officers elected include *Dr. Raymond Yost*, Manitowoc, vice-president; *Dr. L. D. Sobush*, Manitowoc, secretary–treasurer; Doctor Sobush and Doctor Strong, delegates; Doctor Yost, *Dr. Walter Scherping* of Manitowoc, and *Dr. Nelson Bonner*, Manitowoc, alternate delegates.

The chapter members voted to assist the Manitowoc Cancer Society in its program of education relating to cancer and to furnish speakers to appear before various city and county groups.

Northeastern Wisconsin Chapter, Academy of General Practice

About 40 physicians and surgeons in general practice in the Green Bay area met at Green Bay on January 25, at which time a new chapter of the American Academy of General Practice was formed for Brown, Kewaunee, and Door counties.

Dr. William Hildebrand of Menasha, national Academy president; *Dr. Clarence McDonald*, Milwaukee, state president; *Dr. Robert F. Purtell*, Milwaukee, state secretary; and *Dr. C. G. Reznichek*, Madison, and *Dr. George Forkin*, Menasha, past officers of the state organization, were among those present.

The following were elected as officers of the new chapter:

President—*Dr. M. L. Kuhs*, Green Bay
Vice-President—*Dr. T. S. Burdon*, Green Bay
Secretary-Treasurer—*Dr. Frank Urban*, Green Bay
Delegate, Brown County—*Dr. John Goelz*, Green Bay
Alternate Delegate, Brown—*Dr. E. R. Killeen*, Green Bay
Delegate, Kewaunee County—*Dr. E. W. Witcpalek*, Kewaunee
Alternate Delegate, Kewaunee—*Dr. R. M. Nesemann*, Kewaunee
Delegate, Door County—*Dr. J. G. Beck*, Sturgeon Bay
Alternate Delegate, Door—*Dr. C. W. Stiehl*, Algoma

Milwaukee Academy of Medicine

The Milwaukee Academy of Medicine met at the University Club, Milwaukee, on February 15 to hear Dr. Tracy Jackson Putnam, chief of the Department of Neurosurgery, Cedars of Lebanon Hospital, Los Angeles, speak on "The Nature and Treatment of Multiple Sclerosis." This was an Arthur W. Rogers Memorial Lecture.

On February 16, a dinner meeting and clinic were held at the General Hospital Theater, Veterans Administration. Members of the Milwaukee Neuro-Psychiatric Society and their guests were invited to attend.

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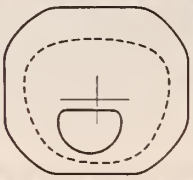

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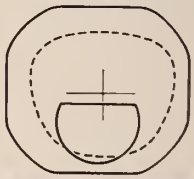

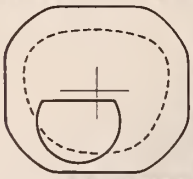

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Something New in

ANNUAL MEETING ROUND TABLES

Because of difficulties in food service at luncheons preceding round tables, arrangements have been made with the Milwaukee Auditorium to have cafeteria food service available, and all round tables will be held at the Milwaukee Auditorium. The programs will start promptly at 1:00 p.m., and there will be no need to leave the building between the close of the morning program and the beginning of the discussions.

No Charge, But Admittance By Ticket Only

Without food service, there will be no charge for attendance at the round tables, *but admittance will be by ticket only* and attendance at each will be limited strictly to the size indicated.

How Tickets Secured

READ CAREFULLY

Advance reservations will be accepted in the order received, until the maximum number has been reached. Tickets will be issued at the Registration Desk in the Auditorium, and all reservations not confirmed by 10:00 a.m. each day will be cancelled if additional reservations are still unfilled.

In making your advance reservations (see insert for the form to use), be sure you specify three choices in order of preference.

ROUND TABLE SCHEDULE

Tuesday, May 3:

1. **Regional Enteritis: Its Present-Day Management:** J. Arnold Bargen, M. D., Mayo Clinic (M. C. F. Lindert, M. D., Milwaukee, chairman)

2. **Abuses in Proctology:** Robert Turell, M. D., New York City (Carl W. Eberbach, M. D., Milwaukee, chairman)

3. **Suicide:** John Romano, M. D., Rochester, New York (Joseph A. Kindwall, M. D., Milwaukee, chairman)

4. **The Postphlebitic Syndrome:** James E. Conley, M. D., Milwaukee

5. **Plantar Warts and Calluses:** Donald M. Ruch, M. D., Milwaukee, and Wallace C. Miller, M. D., Racine

6. **Meeting Problems of Hemorrhage in Obstetrics:** Frederick J. Hofmeister, M. D., Milwaukee

Wednesday, May 4:

1. **The Role of Regional Anesthesia in Surgery, Obstetrics, Diagnosis and Therapy:**
   John J. Bonica, M. D., Tacoma, Washington, guest speaker
   Sidney Orth, M. D., Madison, moderator
   Panel Participants: Robert Wylde, M. D., Madison (surgery); George S. Kilkenny, M. D., Milwaukee (obstetrics); and Anthony Tella, M. D., Milwaukee (nonsurgical diseases)

2. **Incontinence of Urine in Women:** Richard TeLinde, M. D., Baltimore (Frederick J. Hofmeister, M. D., Milwaukee, chairman)

3. **Sudden Illnesses in Children:** Lee Forrest Hill, M. D., Des Moines, Iowa (John C. Peterson, M. D., Milwaukee, chairman)

4. **The Place of Radioiodine in Medicine:** Earl R. Miller, M. D., San Francisco (Hans W. Hefke, M. D., Milwaukee, chairman)

5. **The Treatment of Ligament Injuries About the Knee:** Don H. O'Donoghue, M. D., Oklahoma City (Albert C. Schmidt, M. D., Milwaukee, chairman)

6. **Current Concepts in the Treatment of Pulmonary Lesions:** Ivan Baronofsky, M. D., Minneapolis (Joseph W. Gale, M. D., Madison, chairman)

7. **The Choice of Hypertensive Patients for Sympathectomy:** James A. Evans, M. D., Boston (Charles Crumpton, M. D., Madison, chairman)

8. **Newer Drugs and Their Uses:** Ovid O. Meyer, M. D., Madison

ROUND TABLES : (cont.)

Thursday, May 5:

1. **Chronic Relapsing Pancreatitis:** Herbert Lee, M. D., Richmond, Virginia (Kenneth Lemmer, M. D., Madison, chairman)
2. **The Surgical Treatment of Aneurysms and Obstructive Lesions of the Aorta and Peripheral Arteries:** Harris B. Shumacker, Jr., M. D., Indianapolis (Paul F. Hausmann, M. D., Milwaukee, chairman)
3. **Air Embolism:*** Charles P. Larson, M. D., Tacoma, Washington (Dann B. Claudon, M. D., Milwaukee, chairman)
4. **Can the Cardiac Patient Work?** Joseph G. Benton, M. D., New York City (Howard L. Correll, M. D., Milwaukee, chairman)
5. **The Management of Abortion:** William F. Geittmann, M. D., Chicago (Benjamin E. Urdan, M. D., Milwaukee, chairman)
6. **Problems and Advances in the Treatment of Diabetes:** Bruno Peters, M. D., Milwaukee

* Official meeting of Wisconsin Society of Pathologists immediately following close of discussion, at 2:00 p.m.

Annual Dinner Features

HOTEL SCHROEDER, THURSDAY, MAY 5—$6.00 PER PLATE

SHORT FORMAL PROGRAM: Short talks by President Arthur J. McCarey and incoming president E. L. Bernhart.

HONORS TO NEW MEMBERS OF "50 YEAR CLUB": The following members will be granted certificates and pins as newly qualified members of the "50 Year Club":

OTTO F. DIERKER, M. D. ..... Watertown
EDW. S. ELLIOTT, M. D. ..... Fox Lake
CHARLES H. FEASLER, M. D. ..... Oconomowoc
GEORGE E. FORKIN, M. D. ..... Menasha
LEOPOLD J. FRIEND, M. D. ..... Beloit
JOSEPH J. GRAMLING, Sr., M. D. ..... Milwaukee
FRANK H. KELLEY, M. D. ..... Merrill
OSCAR KNUTSON, M. D. ..... Osseo
FREDERICK K. KOLB, M. D. ..... Sheboygan
WILLIAM T. LINDSAY, M. D. ..... Madison
JOSEPH W. LIVINGSTONE, M. D. ..... Hudson
HOMER D. LUDDEN, M. D. ..... Mineral Point
WILLIAM LUMSDEN, M. D. ..... Menomonie
HARRY H. MEUSEL, M. D. ..... Oshkosh
ENOCH F. PETERSON, M. D. ..... Milwaukee
JAMES J. ROBB, M. D. ..... Green Bay
CHARLES A. SQUIRE, M. D. ..... Sheboygan
WM. J. WALDSCHMIDT, M. D. ..... Fond du Lac
SIDNEY H. WETZLER, M. D. ..... Milwaukee
ARTHUR G. WILCOX, M. D. ..... Solon Springs

"THERE *IS* A DOCTOR IN THE HOUSE": The Fond du Lac County Medical Society Auxiliary will present a humorous skit as a part of the program. Participants will be Ramona Huebner, Mildred Becker, Marilyn Coyne, Phyllis Kendell, Agatha Mauthe, Peg Cerny, Phyllis Myers, and Mary Kief. Dr. F. J. Cerny will be at the piano.

FLOOR SHOW AND DANCE: In addition to the skit of the Fond du Lac County Medical Society Auxiliary, there will be a professional floor show; and from 10:00 p. m. to midnight there will be dancing to the orchestra of Steve Swedish and his band.

MAKE YOUR RESERVATIONS EARLY . . . ONLY 450 CAN BE ACCOMMODATED

(Use the Reservation Form on the Insert Facing Page 50)

J. ARNOLD BARGEN, M. D.

Professor of Medicine, Mayo Foundation, Rochester, Minnesota

TUESDAY, MAY 3:

"The Role of Cortisone and Corticotropin in Gastrointestinal Disorders"

Round Table: "Regional Enteritis: Its Present-Day Management"

JOSEPH G. BENTON, M. D.

Associate Professor of Physical Medicine and Rehabilitation, New York University College of Medicine

THURSDAY, MAY 5:

"Rehabilitation of the Patient with Cardiovascular Disease"

Round Table: "Can the Cardiac Patient Work?"

JOHN J. BONICA, M. D.

Tacoma General Hospital, Tacoma, Washington

WEDNESDAY, MAY 4:

"What's New in Anesthesiology"

"The Proper Role of the Anesthesiologist in the Management of Pain"

Round Table: "The Role of Regional Anesthesia in Surgery, Obstetrics, Diagnosis and Therapy"

JAMES A. EVANS, M. D.

Chief of Vascular Section, Department of Internal Medicine, Lahey Clinic, Boston

WEDNESDAY, MAY 4:

"What's New in Drug Therapy Related to Hypertension"

"Modern Management of the Hypertensive Patient"

Round Table: "The Choice of Hypertensive Patients for Sympathectomy"

BRUCE FRALICK, M. D.

Professor of Ophthalmology, University of Michigan Medical School, Ann Arbor

THURSDAY, MAY 5:

"Periorbital Lesions"

WILLIAM F. GEITTMANN, M. D.

Assistant Professor of Obstetrics and Gynecology, Northwestern University Medical School, Chicago

THURSDAY, MAY 5:

"Shoulder Presentation"

Round Table: "The Management of Abortion"

LEE FORREST HILL, M. D.

Des Moines, Iowa

WEDNESDAY, MAY 4:

"What's New in Pediatrics"

"Emergencies in the Newborn Period"

Round Table: "Sudden Illnesses in Children"

CHARLES P. LARSON, M. D.

Assistant Clinical Professor of Pathology, University of Washington Medical School, Seattle

THURSDAY, MAY 5:

"Investigation of the Unknown Dead"

Round Table: "Air Embolism"

HERBERT C. LEE, M. D.

Professor of Clinical Surgery, Medical College of Virginia, Richmond

THURSDAY, MAY 5:

"Present Therapy of Benign and Malignant Breast Conditions"

Round Table: "Chronic Relapsing Pancreatitis"

EARL R. MILLER, M. D.

Professor of Radiology, University of California Medical School, San Francisco

TUESDAY, MAY 3:

"The Place of Image Amplifiers and X-ray Movies in Radiology"

WEDNESDAY, MAY 4:

"What's New in Radiology"

Round Table: "The Place of Radioiodine in Medicine"

DON H. O'DONOGHUE, M. D.

Professor and Chairman, Department of Orthopedic and Fracture Surgery, University of Oklahoma School of Medicine, Oklahoma City

WEDNESDAY, MAY 4:

"What's New in Orthopedics"

"The Importance of Early Treatment of Injuries to Athletes"

Round Table: "Treatment of Ligament Injuries About the Knee"

JOHN ROMANO, M. D.

Professor of Psychiatry, University of Rochester School of Medicine, Rochester, New York

TUESDAY, MAY 3:

"The Doctor–Patient Relationship"

Round Table: "Suicide"

HARRIS B. SHUMACKER, JR., M. D.

Professor and Chairman, Department of Surgery, Indiana University School of Medicine, Indianapolis

THURSDAY, MAY 5:

"What Does Surgery Offer the Cardiac Patient?"

Round Table: "The Surgical Treatment of Aneurysms and Obstructive Lesions of the Aorta and Peripheral Arteries"

RICHARD TeLINDE, M. D.

Professor of Gynecology, Johns Hopkins University School of Medicine, Baltimore

TUESDAY, MAY 3:

"Unjustified Gynecological Operations"

WEDNESDAY, MAY 4:

"What's New in Gynecology"

"Endometriosis"

Round Table: "Incontinence of Urine in Women"

GEORGE J. THOMAS, M. D.

Associate Professor of Surgery, Department of Anesthesiology, University of Pittsburgh School of Medicine, Pittsburgh

THURSDAY, MAY 5:

"Fire and Explosion Hazards in Hospitals, and Their Control"

ROBERT TURELL, M. D.

Assistant Professor of Surgery in Proctology, Albert Einstein Medical School, New York City

TUESDAY, MAY 3:

"Adenomas and Hemorrhoids: Problems of Rectal Bleeding"

Round Table: "Abuses in Proctology"

SPEAKERS WHOSE PICTURES WERE NOT AVAILABLE AT TIME OF PUBLICATION

IVAN BARONOFSKY, M. D.

Associate Professor of Surgery, University of Minnesota Medical School, Minneapolis

TUESDAY, MAY 3:

"Esophageal Hiatus Hernia: Its Fate and Treatment"

WEDNESDAY, MAY 4:

"What's New in Surgery?"

Round Table: "Current Concepts in the Treatment of Pulmonary Lesions"

BEN H. SENTURIA, M. D.

Associate Professor of Otolaryngology, Washington University School of Medicine; Director of Department of Otolaryngology, Jewish Hospital, St. Louis, Missouri

THURSDAY, MAY 5:

"The Treatment of External O itis"

Hosts For Guest Speakers

The following physicians will serve as hosts for our guest speakers during their visit with us in Milwaukee

Guest	Host
J. ARNOLD BARGEN	A. C. GORDER, Milwaukee
IVAN BARONOFSKY	J. M. SULLIVAN, Milwaukee
JOSEPH G. BENTON	R. G. PIASKOSKI, Wood
JOHN J. BONICA	J. W. TEMPLE, Milwaukee
JAMES A. EVANS	H. W. POHLE, Milwaukee
BRUCE FRALICK	H. G. SCHMIDT, Milwaukee
WILLIAM F. GEITTMANN	L. T. SERVIS, Milwaukee
LEE FORREST HILL	J. C. PETERSON, Milwaukee
CHARLES P. LARSON	M. B. LLEWELLYN, Janesville
HERBERT C. LEE	H. J. LEE, Milwaukee
EARL R. MILLER	R. W. BYRNE, Milwaukee
DON H. O'DONOGHUE	W. P. BLOUNT, Milwaukee
JOHN ROMANO	L. J. VAN HECKE, Milwaukee
BEN H. SENTURIA	H. C. HIGH, Milwaukee
HARRIS B. SHUMACKER	C. M. SCHROEDER, Milwaukee
RICHARD TE LINDE	R. S. CRON, Milwaukee
GEORGE J. THOMAS	RICHARD FOREGGER, Milwaukee
ROBERT TURELL	R. T. McCARTY, Milwaukee

SCIENTIFIC EXHIBITS

Reflect Varied and Significant Research of Wisconsin Physicians and Medical Groups

The scientific exhibits listed below have been selected for the 1955 Annual Meeting by L. G. Kindschi, M.D., Monroe, a member of the Council on Scientific Work. The exhibits will be located in Bruce Hall of the Milwaukee Auditorium.

Provision has been made on the time schedule so that these fine exhibits can be studied in the early morning hours before the formal scientific meetings and at the close of the morning sessions before lunch, as well as during a special recess period in the afternoon. The Council on Scientific Work appreciates the effort which went into the preparation of these exhibits and recommends that all physicians attending the Annual Meeting study their content and discuss the material with those in attendance.

S-7a—TUMORS AND DISEASES OF THE SALIVARY GLANDS

R. P. Gingrass, M. D., D. D. S., Milwaukee

The exhibit will consist of Kodachrome transparencies demonstrating benign and malignant tumors of the salivary glands, cysts ranulae, sialolithiasis, Mikulicz's disease, tumors arising from aberrant salivary gland tissue in lips, palate, tongue, etc. Incisions for exposure of parotid tumors, preserving the facial nerve, salivary fistulas, etc., will be shown.

S-8, 9—ELECTROCARDIOGRAPHIC PITFALLS

R. H. Wasserburger, M. D., and T. H. Lorenz, M. D., Veterans Administration Hospital and University Hospitals, Madison

Information given includes data on a large series of Negro and Caucasian patients who, although exhibiting normal QRS complexes, showed persistent and marked RST and T wave abnormalities in the precordial leads. The mode of production of these abnormalities through brief hyperventilation is shown in serial electrocardiographic tracings; ameliorating effects of reassurance, potassium salts, and intravenous Pro-Banthine are shown. Pertinent clinical summaries are also included.

S-10, 11—TRIGEMINAL NEURALGIA

H. M. Suckle, M. D., Madison

The exhibit will depict the diagnosis, the pathology, and the medical and surgical treatments of trigeminal neuralgia. The medical treatments will include the latest forms of injection therapy. Advancements in surgical treatment that have been used in the past several years, including section of the nerve and decompression of the gasserian ganglion, will also be shown.

S-12, 13—FACIAL FRACTURES

F. D. Bernard, D. D. S., M. D., Madison, and the University of Wisconsin Medical School

The exhibit will cover the matter of diagnosis and treatment, and there will be illustrative material in the form of colored photographs.

S-14a—ADENOMAS OF THE COLON AND RECTUM

Robert Turell, M. D., Albert Einstein Medical School, New York City

This exhibit deals with the incidence, distribution, types, genesis, familial tendency, cancer potential, and treatment of discrete, single or multiple scattered adenomas. Practically all of these items are illustrated by means of black and white and colored gross and/or microscopic transparencies. The text is precise, clear, and short. The major portion of the exhibit is devoted to treatment and illustrates the newest electrothermic methods and surgical technics.

S-14, 15—SURGICAL TREATMENT OF VARICOSE VEINS BY STRIPPING TECHNIC

T. T. Myers, M. D., K. A. Lofgren, M. D., and L. R. Smith, M. D, Mayo Clinic, Rochester, Minnesota

Varicose veins of the lower extremity are progressive, recurring, and disabling. They have not responded satisfactorily to minor surgery and injection therapy. The most satisfactory long-term control has been accomplished by major surgery which consists of extensive removal of the veins by stripping and direct dissection.

The exhibit consists of (1) models, diagrams, and photographs explaining the technic of stripping the long saphenous and the short saphenous veins; (2) illustrations of the important venous patterns from a surgical

standpoint; (3) simplified diagnostic tests and venous pressure studies before and after surgery; and (4) graphs showing the results of partial stripping and complete stripping performed on 1,189 lower extremities.

S-16, 17—PRIMARY TUMORS OF THE SOFT TISSUES OF THE EXTREMITIES, EXCLUSIVE OF EPITHELIAL TUMORS (An Analysis of 500 Consecutive Cases)

E. H. Soule, M. D., R. K. Ghormley, M. D., H. H. Young, M. D., M. B. Coventry, M. D., P. R. Lipscomb, M. D., P. M. Janes, M. D., J. C. Ivins, M. D., E. D. Henderson, M. D., W. H. Bickel, M. D., and E. W. Johnson, Jr., M. D., Mayo Clinic, Rochester, Minnesota

This exhibit is based on our experience with soft tissue tumors of the extremities (exclusive of epithelial tumors), with emphasis on gross and microscopic appearance of these tumors. Six major groups to be shown are: (1) fibromatous tumors; (2) myomatous tumors; (3) lipomatous tumors; (4) neuromatous tumors; (5) angiomatous tumors; and (6) miscellaneous tumors.

A benign tumor and its malignant counterpart will be demonstrated whenever practicable. The diagnosis of such tumors hinges upon biopsy studies of the presenting mass, and definitive treatment of the lesion must be based on these findings.

S-18—CANCER PROBLEMS IN INFANCY AND CHILDHOOD

H. A. Waisman, M. D., Department of Pediatrics, University of Wisconsin Medical School

The material is presented in the form of Kodachrome illustrations of tumors and some examples of histological variations of neoplasms as they occur in infancy and childhood. Results of therapy are explained.

S-19—COMPARISON OF MORBIDITY AND MORTALITY-TUBERCULOSIS, CANCER, AND CARDIAC DISEASE—BY SEX AND AGE

Wisconsin Anti-Tuberculosis Association

The highest morbidity and mortality from pulmonary tuberculosis, cancer of the bronchi and lungs, and cardiac disease occurs in the middle and older age groups, particularly among males. In this exhibit, these facts will be graphically portrayed by means of x-ray illustrations.

Early evidence of pathology may often be found on routine hospital admission x-ray films in patients hospitalized for other reasons.

S-20, 21—RESEARCH AND TEACHING AT COLUMBIA HOSPITAL

The exhibit shows various phases of the diagnostic, therapeutic, and teaching activities carried on by the staff of Columbia Hospital, Milwaukee.

S-22—E.E.G. IN DIAGNOSIS OF NEUROLOGICAL DISORDERS

F. J. Millen, M. D., and M. J. Primakow, M. D., Marquette University School of Medicine and VA Hospital, Wood

This exhibit shows the use and value of E.E.G.'s in the diagnosis of common neurological disorders. It consists of clinical cases, histories, and typical electroencephalographic findings. Sample E.E.G.'s will be demonstrated, and an electroencephalograph machine may be present in the booth for a demonstration.

S-23—THE ISOLATED HEART

Harry Beckman, M. D., Marquette University School of Medicine, and the Wisconsin Heart Association

S-24, 25—DERMATOLOGIC LESIONS IN GENERAL PRACTICE

R. J. Rowe, M. D., and H. C. Dangle, M. D., Marshfield Clinic, Marshfield

The exhibit consists of 40 enlarged Kodachrome pictures of malignant and nonmalignant lesions seen on the skin. There are accompanying legends giving a brief description of the clinical and pathologic findings and treatment. In addition we have 2 x 2 Kodachrome slides of representative pathologic sections and some 2 x 2 clinical slides for variety. The exhibit is an alteration of the one shown two years ago; additions and substitutions have been made.

S-25a—DIFFERENTIAL DIAGNOSIS OF BREAST TUMORS

Milwaukee and Wisconsin Divisions, American Cancer Society

This exhibit was prepared under the direction of Dr. Cushman D. Haagensen, Director, Cancer Research Institute, Columbia-Presbyterian Medical Center, New York City, and depicts by use of photographs and charts the subject matter conveyed in the title.

S-25b—CONGENITAL ABSENCE OF THE VAGINA AND ITS SURGICAL CORRECTION

E. A. Habeck, M. D., Department of Gynecology and Obstetrics, Deaconess Hospital, Milwaukee

The exhibit will demonstrate the modern surgical correction of this centuries-old female congenital defect. The procedure is today recognized on the European and American continents as the most successful, safe, and feasible method of correction. Moulds and procedures and technic, together with proper aftercare, are demonstrated. Reasons for failure are pointed out, and the necessary requirements for success are emphasized.

S-26, 27—GROSS TISSUE DEMONSTRATIONS

Section on Pathology and the Wisconsin Society of Pathologists

Fixed and fresh gross pathological specimens will be demonstrated by various pathologists.

S-28, 29—Anatomy Department, Marquette University School of Medicine

(Description will be listed in April *Journal*).

S-30, 31—HAZARDS OF SOLVENTS: AT HOME AND ON THE JOB

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News Items and Personals

Dr. William McLane Leaves Gilman

Dr. William McLane, who had been practicing at Gilman since 1951, has left to accept a post in the Student Health Service at the University of Illinois at Champaign.

Members of the Gilman Lions Club and their wives entertained Doctor and Mrs. McLane at a dinner party on January 12 at Koolmo's Club, west of the community. The doctor was presented with a desk set as a farewell gift.

Two Rivers Hospital Staff Elects Officers

At the annual meeting of the medical staff of the Two Rivers Municipal Hospital during the week of January 16, *Dr. A. P. Zlatnik* was elected as president; *Dr. R. E. Martin*, vice-president; and *Dr. D. A. Kuljis*, secretary. All are from Two Rivers.

Hartford Hospital Staff Officers Elected

When the medical staff of St. Joseph's Hospital, Hartford, met during the week of January 9, *Dr. J. G. Hoffmann* was elected chief; *Dr. Maurice Monroe*, vice-president; and *Dr. Theodore Kern*, secretary–treasurer. The officers are all Hartford physicians.

Doctor Olson Attends Class in Internal Medicine

Dr. L. L. Olson of Darlington attended a class in internal medicine in New York during the week of January 16.

Doctor Doeringsfeld Chief of Staff

Dr. H. L. Doeringsfeld, Platteville, was elected chief of staff of the Platteville Municipal Hospital recently. He succeeds *Dr. Wilson Cunningham.*

Doctor Samuelson Returns to Hartland

Discharged from the Army in January, *Dr. Clarence Samuelson* has returned to Hartland to practice. He opened his new office in the Legion Building about February 1.

Sheboygan Doctors Attend Marquette Classes

Dr. W. W. Moir and *Dr. H. J. Winsauer* of Sheboygan recently attended classes in radioisotope therapy at Marquette University. They also spent several days in Madison at the Wisconsin General Hospital, visiting its radioisotope laboratory.

Dr. Florence Duckering at Peru Meeting

Dr. Florence Duckering, Sheboygan, attended a meeting of the American College of Surgeons in Peru recently. The meeting was held at Lima.

Doctor Crawford at Tacoma Air Base

Dr. Chester W. Crawford is now located at McChord Air Force Base, Tacoma, Washington, and is connected with the 567th Air Force Hospital. He is working in the general medicine department of the outpatient clinic as well as doing the x-ray work for the hospital. Doctor Crawford formerly practiced in Madison.

New Medical Director at Rogers Sanitarium

Dr. Owen Otto has been appointed medical director of Rogers Memorial Sanitarium at Oconomowoc. His appointment took effect on February 1.

THIRD AND TWELFTH DISTRICTS NEWS

Staff Officers Elected at Beloit Hospital

At the annual meeting of the Beloit Hospital staff on February 1, the following Beloit physicians were elected staff officers for the new year:

President—*Dr. W. L. Cochrane*
President-Elect—*Dr. R. F. Wilson*
Secretary-Treasurer—*Dr. E. T. Rechlitz*
Executive Committee—*Drs. R. M. Baldwin, George Peterson*, and *R. J. Sanderson*

Heart Association Forum in Milwaukee

About 750 Milwaukeeans attended a forum sponsored by the Wisconsin Heart Association at the Milwaukee Vocational School Auditorium on February 2. Panel members were *Dr. Forrester Raine*, clinical professor of surgery at the Marquette University School of Medicine; *Dr. John C. Peterson*, director of the Department of Pediatrics at the school and pediatrician in chief at Milwaukee Children's Hospital; *Dr. Maurice Hardgrove*, an associate professor of medicine at Marquette; and *Dr. George A. Hellmuth*, director of the Cardiovascular Section of the medical school and chief of cardiology at Milwaukee County General Hospital.

District Judge Robert W. Hansen was moderator, and program director was *Dr. Raymond L. Rice*, chairman of the Milwaukee County Heart Committee.

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Doctor Osborn Addresses Health Council

The Polk County Health Council held its second conference at Luck on February 4 and 5, aided by the Wisconsin State Division of Mental Hygiene, the Polk public schools, and the Polk County Medical Society. The conference theme was "What a Child's Behavior May Mean." *Dr. Leslie Osborn*, director of mental hygiene for the Wisconsin Department of Public Welfare, addressed the group on February 4 on "Behavior and Emotional Health as Reflected in the Community Setting."

Doctor Warner Speaks to Nurse Anesthetists

Dr. Raymond C. Warner, Milwaukee specialist in ophthalmology, spoke to members of the Wisconsin Association of Nurse Anesthetists at the Pfister Hotel, Milwaukee, on February 5. About 100 persons attended the meeting. His subject was "Surgery of Cataracts of the Eyes and Use of Sodium Pentothal Anesthesia."

Dr. J. W. Temple, clinical instructor in anesthesiology at the Marquette University School of Medicine, spoke on the effect of Sodium Pentothal on respiration.

Dr. R. E. Burns Elected President of International Society

Dr. Robert E. Burns, Madison, has been elected president of the International Society of Orthopedic Surgeons and Traumatologists, which has its headquarters in Brussels, Belgium. Doctor Burns is chairman of the Section on Orthopedic Surgery at the University of Wisconsin Medical School.

University of Wisconsin Medical School Society

When the Medical School Society of the University of Wisconsin met on February 15 in the auditorium of the Service Memorial Institute, Madison, Dr. Robert J. Rohn spoke on "Some Hematological Observations in Acute Disseminated Lupus Erythematosus." Doctor Rohn is assistant professor of medicine and director of hematology research at Indiana University School of Medicine.

Sherrington Society of Wisconsin Meets

The fifth annual lecture of the Sherrington Society of the University of Wisconsin was presented on February 17 by Dr. Wilder Penfield of the Montreal Neurological Institute. The convocation was held in the auditorium of the Service Memorial Institute.

Doctor Hofmeister Speaks, Conducts Courses in Obstetrics

Dr. F. J. Hofmeister, assistant clinical professor of obstetrics and gynecology at Marquette University School of Medicine, has recently given several talks and conducted a course on obstetrics.

Discussing "Significant Factors in Wisconsin Maternal Deaths, 1953," he spoke at Milwaukee Hospital on January 8, Columbia Hospital on January 11, Mount Sinai Hospital on January 20, and to the nursing supervisors and faculty of Milwaukee Hospital on February 2.

He conducted a course in postgraduate obstetrics at the Milwaukee Hospital on January 16 and 26 and February 2. On February 16, he discussed maternal mortality before a postgraduate obstetric course at the Marquette University Auditorium.

When he addressed a group of physicians and dentists on February 17, his topic was "Gynecologic Carcinoma." This was at a meeting held under the auspices of the Wisconsin branch of the American Cancer Society.

In addition to his other activities, Doctor Hofmeister is serving as a member of the advisory committee on arrangements for a sectional meeting of the American College of Surgeons.

SOCIETY RECORDS

New Members

G. M. Simon,* 926 South Eighth Street, Manitowoc.

R. D. Bragman, 1300 University Avenue, Madison.

R. F. Schilling, 1300 University Avenue, Madison.

C. H. Kratchovil, 119 North Charter Street, Madison.

S. P. Vinograd,* 1901 Monroe Street, Madison.

Herman Tuchman, 1300 University Avenue, Madison.

F. E. Shearer,* Edgerton.

R. W. Schroeder,* 1031 North 33rd Street, Milwaukee.

W. J. Scollard,* 606 West Wisconsin Avenue, Milwaukee.

C. T. Ziegler,* 5856 North Port Washington Road, Milwaukee.

N. J. Kozokoff,* 3348 Colwyn Road, Shaker Heights, Ohio.

R. F. Scheller,* 816 16th Street, Racine.

I. C. Neubauer,* 4939 West Wells Street, Milwaukee.

L. P. Wolf,* 4921 North Ardmore, Milwaukee.

E. F. Brandt,* 2044 North 86th Street, Milwaukee.

Elaine M. Thomas,* 2795 North Carlton Place, Milwaukee.

E. L. Tharinger,* 6300 West Wisconsin Avenue, Milwaukee.

C. J. Becker,* 335 West North Avenue, Milwaukee.

P. P. Meighan,* R. D. 3, Whitewater.

J. A. Jenner,* 945 North 12th Street, Milwaukee.

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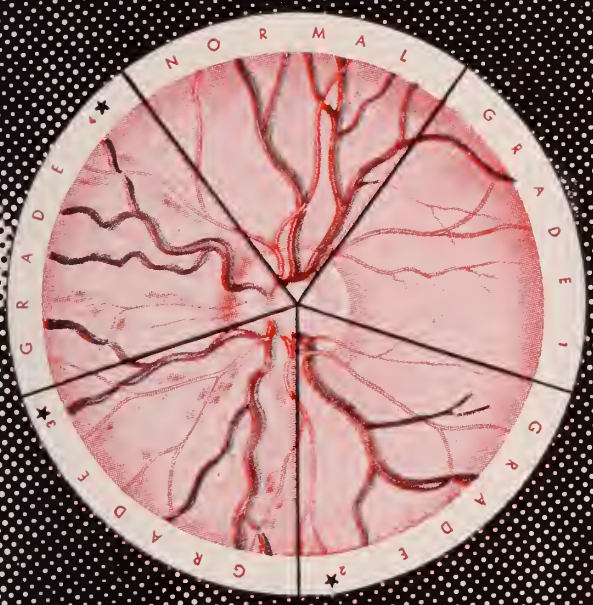

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C. F. Dunn,* 1204 West Wisconsin Avenue, Milwaukee.

Lillian M. Thomas, 519 West Mitchell Street, Milwaukee.

G. A. Hellmuth, 8700 West Wisconsin Avenue, Milwaukee.

R. A. Kebbekus, 2200 West Kilbourn Avenue, Milwaukee.

Donald Caine, 238 West Wisconsin Avenue, Milwaukee.

J. M. Markovitz, 1408 Washington Avenue, Racine.

J. A. McHale, 1008 Illinois, Racine.

Richard Minton, 810 Main Street, Racine.

R. M. Thurow, 221 Main Street, Black River Falls.

E. F. Kuglitsch, 504 Fillmore, Black River Falls.

R. H. Segnitz, 3495 North Murray Avenue, Milwaukee.

F. J. Carpenter, 4835 West Capitol Drive, Milwaukee.

J. A. Pizer, 4602 South Packard Avenue, Cudahy.

DeLore Williams, 3218 South 35th Street, Milwaukee.

C. Hugh Hickey, 4611 North Oakland Avenue, Milwaukee.

G. M. Daley, 4237 North 44th Street, Milwaukee.

R. C. Kory, Veterans Administration Hospital, Wood.

Constantine Panagis, 4300 West Burleigh Street, Milwaukee.

R. P. Saichek, 2803 North 52nd Street, Milwaukee.

J. J. Zimmer, 8428 West Cleveland Avenue, West Allis.

J. D. Stuhler,* 1411 Wauwatosa Avenue, Milwaukee.

A. M. Kohn,* 4888 North 21st Street, Milwaukee.

A. V. Pisciotta,* 8700 West Wisconsin Avenue, Milwaukee.

Frank Balistreri,* 4733 North Hopkins Street, Milwaukee.

M. L. Weber,* 3821 South Howell Avenue, Milwaukee.

Changes of Address

A. H. Twyman, Madison, to 407 Prospect Street, Beloit.

W. J. Bleckwenn, Madison, to 100 Avenue D., N. E., Winter Haven, Florida.

J. A. Marks,** Milwaukee, to 3014 Shenandoah No. 10, Houston, Texas.

W. J. Little, Jr., Phoenixville, Pennsylvania, to 3441 St. Clair Street, Racine.

V. C. Epley,** Prairie du Chien, to 2127 S.U., U.S.A. Disp., Fort Miles, Lewes, Delaware.

Clarence Samuelson, Scott Air Force Base, Illinois, to Hartland.

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DEATHS

J. W. HARRIS

Dr. John Warton Harris, 64, Madison obstetrician and gynecologist, died on January 14 at his home, where he had been confined since November 8, 1954, with a heart condition.

Doctor Harris was born on January 12, 1891, and was graduated from Johns Hopkins University School of Medicine, Baltimore, Maryland, in 1916. He served his internship and residency at Johns Hopkins Hospital in Baltimore. He was assistant obstetrician there from 1916 to 1918, associate obstetrician from 1921 to 1925, and associate professor from 1925 to 1928. In 1928, he moved to Madison.

He was professor and chairman of the Department of Obstetrics and Gynecology at the University of Wisconsin Medical School and obstetrician and gynecologist at the University Hospitals.

He was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association; and he had served on the Committee on Maternal and Child Welfare of the State Society and the Study Committee on Maternal Mortality of this Society.

Doctor Harris was a Diplomate of the American Board of Obstetrics and Gynecology and a member of the Wisconsin Society of Obstetrics and Gynecology; the Central Association of Obstetrics and Gynecology, of which he was a founder; and the American Gynecological Society. He was also a fellow of the American Academy for the Advancement of Science.

In September 1953, a group of former residents of the Department of Obstetrics and Gynecology of the State of Wisconsin General Hospital met to honor Doctor Harris on the occasion of his twenty-fifth year at the University. The John Warton Harris Obstetrical Society was organized, the membership

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

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Brown, H. W.: J. Pediat. 45:419, 1954.

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of which is limited to residents trained by Doctor Harris and the members of his department.

Surviving him are his widow; two sons, Dr. John W., Salt Lake City, Utah, and Thomas I., Chicago; a brother, Robert, Montgomery, Alabama; and a sister, Mrs. Robert S. Montgomery, Reidsville, North Carolina.

Dr. Louis Norman Reis, Middleton, died at a Madison hospital on February 5 while attending a patient. He was 47 years of age.

Doctor Reis was born at Odebolt, Iowa, on October 1, 1907, and was graduated from Creighton School of Medicine at Omaha, Nebraska, in 1950. He interned at St. Mary's Hospital, Madison, and had had postgraduate training at Iowa State College in bacteriology and biochemistry.

He practiced in Madison from 1951 to 1953 and was located at De Forest for eight months in 1953, then opening an office at Middleton.

Prior to World War II, Doctor Reis had worked on the West Coast for a Chicago research firm; and during the war he served for three and a half years in the Navy. He had been certified as an epidemiologist by the Bureau of Medicine of the U. S. Navy and had attended the National Naval Medical Center at Bethesda, Maryland. He served with the Epidemiology Unit 304 in the Pacific Theater as bacteriologist and epidemiologist.

He was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors are his widow, Dr. Jacqueline, who is not in practice at present; a twin son and daughter, Jeffrey Louis and Julie Lynn; another daughter, Pamela Ann; seven sisters; and two brothers.

Dr. James Gillis Garland, 47-year-old Milwaukee physician, died at his home on January 25 following a heart attack suffered the previous week.

Doctor Garland was born in Antigo on August 12, 1907. He received his medical education at Marquette University School of Medicine, from which he was graduated in 1932; and he served his internship and residency at Milwaukee County Hospital. In 1934 he began his practice in Milwaukee.

He served as a lieutenant commander in the U. S. Naval Reserve from November 1944 to May 1946, stationed at Mare Island, California, and later on a transport ship.

He was a Diplomate of the American Board of Surgery; a Fellow of the American College of Surgeons; and a member of the Milwaukee Surgical Society, the Wisconsin Surgical Society, and the Milwaukee Academy of Medicine. He was associate professor of surgery at Marquette University School of Medicine, chief of surgery at St. Luke's Hospital from 1947 to 1952, chief of staff of Milwaukee

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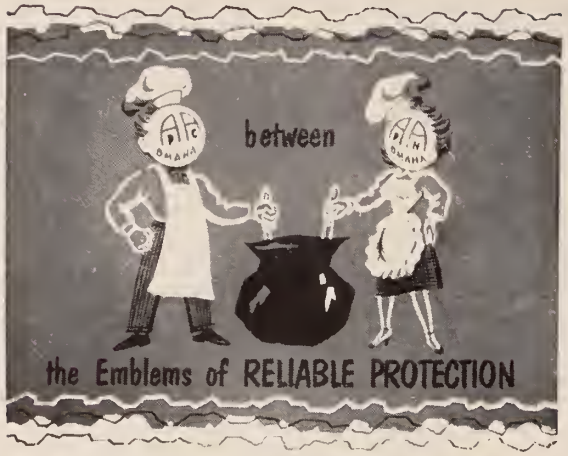

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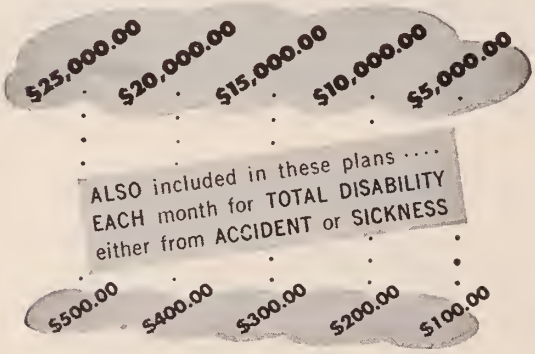

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County Hospital in 1949, and a member of the faculty of the Marquette Postgraduate School.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. In 1953 and 1954 he was secretary of the Section on Surgery of the State Society and in 1954, president of the Milwaukee County Society.

Survivors are his widow, Ruth; a daughter, Judith Ann; a son, Michael John; his mother, Mrs. Anne Garland, Milwaukee; and a brother, John.

Dr. Will B. Gnagi, Monroe, died suddenly on January 15 while driving his car near his home. Born on August 9, 1898, he was 56 years of age at the time of his death.

He was graduated from Washington University, St. Louis, Missouri, in 1924 and served his internship and residency at Barnes Hospital in St. Louis. He began his practice in Monroe in 1927.

In 1934, Doctor Gnagi founded The Monroe Clinic with his father, the late Dr. W. B. Gnagi, Sr., and Dr. John A. Schindler. It was then known as the Gnagi-Schindler Clinic; and in 1939 when other physicians were brought into the clinic, the name was changed to The Monroe Clinic.

Doctor Gnagi was a Fellow of the American College of Surgeons; a Fellow of the International College of Surgeons; and a member of the Wisconsin Surgical Society, of which he had recently been named president-elect. He was a member of the Green County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association and was a past-president of the county society.

At the time of his death he was chief of staff of The Monroe Clinic and chief of the surgical staff of St. Clare Hospital, Monroe.

Doctor Gnagi presented a paper on "Indications for Surgery in the Treatment of Duodenal Ulcers" at the meeting of the International College of Surgeons at Buenos Aires in August 1950. In April 1954 he was among 500 members of the American College of Surgeons who were guests of English and French surgeons during a European tour.

Survivors include his widow, Neva, and two brothers, Kenneth of Oshkosh, and Peter of Pasadena, California.

REMEMBER WHEN!

Wisconsin medical students need your help. Your contribution to the Student Loan Fund of the State Medical Society is needed now. Contributions are tax deductible on both federal and state returns.

Mrs. McCarey and I Invite you and your wife to enjoy the many features of the 1955 Annual Meeting which have been planned for us by the Council on Scientific Work and the officers of our Auxiliary.

Arthur J. McCarey, M. D.
President

Special Features I Know You Will Enjoy:

Golf: Being a golfer myself, I am especially pleased that this year arrangements have been made to hold the golf tournament the day before our scientific programs begin . . . on Monday, May 2. If you have not already made your reservation for this fine event, I suggest you write Al Luthmers, Medical Society of Milwaukee County, Bankers Building, Milwaukee, for an entry blank.

Scientific Programs: A review of the program features in the colored insert of this *Journal* will indicate to what length the Council on Scientific Work has gone to provide an outstanding program for us. I am particularly pleased to note that we will all meet together for the majority of the sessions and review material in various fields which are of great concern to us as physicians.

Auxiliary Functions: All wives of physicians are welcome to attend the various Auxiliary functions listed. You need not be a member of an organized Auxiliary unit to participate. I know you will enjoy meeting the national president-elect, Mrs. Mason G. Lawson, of Little Rock, Arkansas, and one of the past national presidents, Mrs. H. F. Wahlquist, Minneapolis, as well as our state and county officers and members. Two delightful luncheons have been arranged; also, we hope you will attend the Annual Dinner with your husband on Thursday, May 5.

Annual Dinner: The closing feature of the program on Thursday, May 5, will be our Annual Dinner. It will be extremely informal, but highly entertaining. We will welcome into membership the new physicians who qualify for the "50 Year Club," a few *very brief* speeches will be given, and during the rest of the evening there will be entertainment of the highest quality. One special feature this year will be an amusing skit presented by the Woman's Auxiliary to the Fond du Lac County Medical Society.

I sincerely hope you can and will arrange your schedule to be with us in Milwaukee on May 3–4–5. I feel sure you will find the time well spent, and we in turn will enjoy seeing you.

Arthur J. McCarey, M. D.
President

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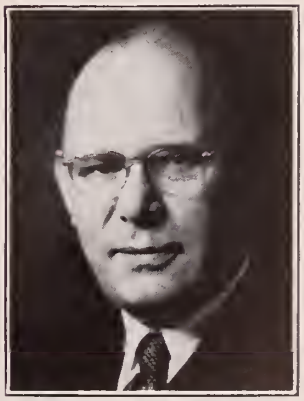

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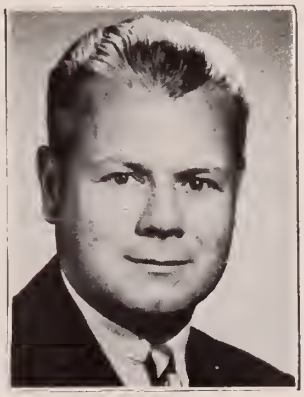

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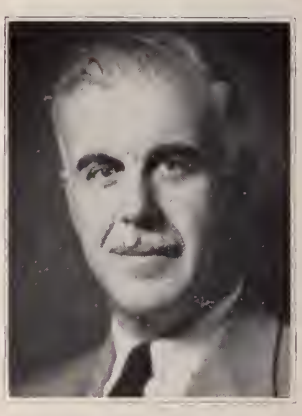

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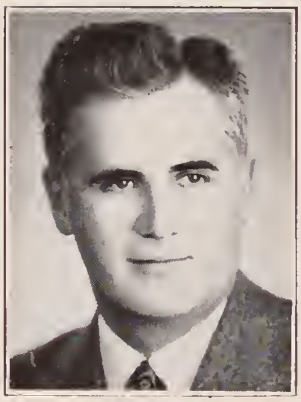

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Surgical Treatment of the Major Neuralgias of the Head*

By GEORGE S. BAKER, M. D.**
Rochester, Minn.

THE management of tic douloureux becomes a surgical issue only when more conservative forms of treatment have failed to relieve the patient of unbearable pain.

It is common knowledge that a patient with a severe form of neuralgia may have spontaneous remission of pain. There seems to be a spring and a fall episode of pain in these cases, such as often occurs with peptic ulcer. Therefore, it is difficult to evaluate the benefit of such drugs as stilbamidine and vitamin B_{12} and other accepted methods of therapy, unless the patient has been followed for many years. A conservative program can be employed as long as the patient is not seriously handicapped by the pain, continues to work, eats normally, and is not forced to use habit-forming drugs in the control of the pain.

When other methods must be used for relief of pain, the neurosurgeon can be consulted with the hope of attaining permanent relief. Treatment then may involve immediate injection of the branches of the painful nerve or an operative procedure and sectioning of the specific nerve or nerves.

Trigeminal neuralgia and glossopharyngeal neuralgia must be differentiated by careful evaluation of the location and distribution of the pain. Provocative tests are necessary for positive identification to delineate which of these nerves is the seat of trouble. For these the tonsillar fossa, posterior part of the tongue, and nasopharynx are cocainized when involvement of the ninth cranial nerve is suspected; and the branches of the fifth cranial nerve are blocked with procaine hydrochloride (Novocaine) when trigeminal neuralgia is suspected. Any atypical neuralgia or pain in the face from other conditions such as vasodilating headache[1] and migraine will not be controlled by such a procedure. When a positive diagnosis can be made, the method of treatment can then be fitted to the needs of the individual patient. The practical, economic, and physical condition of the patient should always be considered in the selection of the correct procedure to control the pain.

Trigeminal Neuralgia[2-4]

In selecting a procedure to satisfy the individual case of tic douloureux, the neurosurgeon must be guided by the knowledge gained from statistical reviews over the years and by his own capabilities and experience in performing a given procedure. For older patients and for those for whom the risk of operation is high, injections of absolute alcohol into the involved branches of the fifth cranial nerve may give palliative relief for six months to two years. Avulsion of the terminal branches of the nerves also may be tried for relief. However, when these procedures fail, many neurosurgical operations that will give permanent relief are performed on the fifth nerve. The subtemporal approach and section of the posterior sensory root, as described by Frazier and Spiller,[5] is probably the safest procedure when the root is to be cut. The operative mortality subsequent to this procedure when it is performed by competent surgeons has been less than 1 per cent. Recurrence of pain in any of the roots after this operation has had a lower incidence than recurrence after other procedures, but the complications of keratitis and paresthesias perhaps occur more frequently than when other procedures are used. When the sensory root is cut at the pons, as Dandy[6] suggested, the mortality rate is higher (3 to 5 per cent) and the incidence of recurrence of pain is higher because of incomplete section of the nerve. Paresthesias are slight after use of this latter surgical technic, and it offers the additional advantage of allowing exploration for aneurysms or tumors in the cerebellopontine angle. The technic involving intramedullary section of the descending root of the fifth nerve (Sjöqvist's

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* Abridgement of paper read at the One Hundred and Thirteenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 6, 1954.

** From the Section of Neurologic Surgery, Mayo Clinic and Mayo Foundation, Rochester, Minnesota. The Mayo Foundation is a part of the Graduate School of the University of Minnesota.

operation)[7] is reserved for young people in good general condition when it is imperative that the motor division of the nerve be spared. The largest incidence of recurrent pain occurs in this group, even though ocular complications are minimal.

In 1952, Taarnhøj[8] of Denmark suggested decompressing the gasserian ganglion and the posterior sensory root of the trigeminal nerve in the hope that sensation to the face would be preserved and the pain likewise controlled. Many operations of this type have been performed in this country, and the procedure has proved to be valuable. The patient must be informed that the pain may recur; our personal experience at the Mayo Clinic with patients followed more than two years shows that the recurrence may be as high as 35 per cent.

Shelden and Pudenz,[9] in Pasadena, have claimed similar results when the gasserian ganglion is merely compressed by an instrument. Yeager, in Philadelphia, reported injection of hot water or saline solution into the space about the gasserian ganglion, with relief of pain. All of these procedures would indicate that we have a lot to learn about the cause of trigeminal neuralgia, and surely an experienced physician must advise the patient as to the procedure of choice when treatment is necessary. The fads of treatment may run their course, but true trigeminal neuralgia seems to go on forever.

Glossopharyngeal Neuralgia[10]

This form of major neuralgia of the face occurs much less frequently than trigeminal neuralgia, but the pain is just as severe and may debilitate older patients very rapidly as they refuse to swallow and become undernourished. At times cocainization of the throat is necessary to allow the hospital patient to eat good nourishing meals for three or four days before operation is undertaken. Intracranial section of the ninth cranial nerve gives permanent relief from the pain. Usually it is advisable to include section of the upper rootlets of the tenth nerve at the same time. Only when the rootlets of the vagus are cut is there any evidence of anesthesia in the tonsillar area and nasopharynx. The patients rarely are aware of this loss of sensation and do not complain of it.

Of all the patients that the neurosurgeon treats for pain, those with neuralgia of the ninth or the fifth cranial nerves seem the most grateful when they are completely relieved.

Mayo Clinic.

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SYMPOSIUM ON OFFICE PROCEDURES AND CLINICAL MEDICINE

Under the joint sponsorship of the Wisconsin Academy of General Practice and Lederle Laboratories, a one-day symposium on Office Procedures and Clinical Medicine will be held on Friday, June 24, at the Madison East Side Businessmen's Club, Madison. Nationally known speakers will present lectures on office proctology, management of extremity fractures, poliomyelitis, office management of allergy, and infertility. Further details will be given in the May issue of the *Journal.*

Retrolental Fibroplasia*

By JUSTIN M. DONEGAN, M. D.
Chicago

THE story of retrolental fibroplasia is unique in the annals of medical history. In the relatively brief period of 12 years since this disease was first mentioned in medical literature, its clinical course has been completely described; its pathology, from the earliest stages to the final tragic end results, elucidated; and, in the last two years, its typical lesions reproduced in several species of animals and its major etiological factor clearly established.

When Terry[1] first found a vascularized membrane behind each lens in four markedly premature infants, he surmised that connective tissue had developed around the embryonic blood vessels of the hyaloid artery and *tunica vasculosa lentis* systems. Later, Reese and Payne[2] developed the thesis that the changes observed were due to persistence and hyperplasia of the primary vitreous; and in 1949 Owens and Owens[3] established the fact that the condition develops after birth in an originally normal eye. At present the clinical manifestations of the disease are well known and consist, in the earliest stages, of an infrequently observed transient period of vasoconstriction followed by the more frequently seen picture of dilatation and tortuosity of the retinal vessels and whiteness and blurring of the periphery of the retina. Vitreous clouding is commonly present, and retinal hemorrhages and new capillary growth may be seen. This fundus picture may disappear completely, or the disease may progress to the cicatricial stage; here the classification, Grades I to V, is commonly used and indicates varying degrees of severity of the involvement. The classification is one recommended by the joint committee on retrolental fibroplasia of the National Society for the Prevention of Blindness. Following is a brief description of the grades in the classification:

I. There is a small mass of opaque tissue in the periphery of the fundus without visible retinal detachment. The fundus may be pale, or there may be residual retinal pigment disturbance. The blood vessels may be attenuated, and these eyes are often myopic.
II. A mass of opaque tissue, larger than that in Grade I, is seen in the periphery of the retina, the disk is pale, and it is distorted because of traction toward the side of the tissue. This traction is usually toward the temporal area of the fundus.
III. A retinal fold or folds extend from the mass of opaque tissue in the periphery to the disk; the mass is larger than that in Grade II.
IV. A retrolental detached mass covers part of the pupillary area.
V. A complete retrolental mass covers the entire pupillary area. Frequently, the anterior chamber is shallow and anterior and posterior synechiae are present. The eye is often small, the upper (and sometimes the lower) lid is retracted, and enophthalmos is present.

Grades IV and V develop in about one-fourth of the infants who have active retrolental fibroplasia, and grades I, II, and III develop in approximately one-third of the cases. The remainder recover with no residual effects. The condition is rarely unilateral and usually involves both eyes in a similar manner.

In discussing the histopathology, it is important to remember that embryologically the retina is different from other tissues in that it is well developed before vessels begin to grow into it, and in that the major elements of retinal vascularization have not been completed until the fetal weight has reached about four pounds. The abnormalities observed histologically in retrolental fibroplasia are, first, sprouting clusters of capillaries which look like glomerular tufts, in the nerve fiber layer, and dense masses of proliferating mesenchymal cells, which produce a thickened nerve fiber layer. Then, the sprouting capillaries, along with strands of

* Presented at the One Hundred and Thirteenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 6, 1954.

connective tissue, soon invade the vitreous; and in the end stages, one finds scarred, atrophic, glomerular-like tufts in a detached retina.

Several pediatric considerations are of importance in this disease. First, the condition occurs almost exclusively in prematurely born infants; and the incidence of retrolental fibroplasia is directly related to the degree of prematurity. During the last 20 years the survival rate of prematures has increased 25 to 30 per cent; but the incidence of blindness in preschool children has increased 500 to 1,000 per cent. The disease may occur in infants of any race and in those of either sex. Prematurely born infants differ from full-term infants in that they are usually extremely anemic and their hemoglobin has an unusual ability to take up oxygen. Frequently, premature infants breathe irregularly. They have poor fat metabolism; and their renal function is impaired, making excretion of electrolytes difficult. In this connection, it should be remembered that cow's milk is much higher in electrolytes than mother's milk. The degree of retardation of infants with retrolental fibroplasia is no different than that of prematures as a whole.

In all the studies concerning the etiology of retrolental fibroplasia, no consistent factors associated with the mother have been determined.

While the intake of water-miscible vitamins and added electrolytes and the ingestion of cow's milk may still be proved to play some role in the production of the disease, it now seems to be clearly established that administration of large quantities of oxygen for prolonged periods of time is an important, probably the most important, factor in the production of retrolental fibroplasia. Ashton and his co-workers[4] have reported the results of a very careful study of the effect of oxygen on the immature kitten retina. The results of their injecting preparations of kitten retina show the vessel-obliterating effect of oxygen and the appearance of glomerular-like tufts after the removal of the animals from oxygen.

Patz[5] has produced typical lesions, analogous to those of early human retrolental fibroplasia, in mice, kittens, rats, and dogs by exposure of the animals to an oxygen-enriched environment. In his experiments the first changes produced were marked vasoconstriction and cessation of the normal progression of vascularization anteriorly. If the exposure to oxygen was for more than three or four days, the retinal vessels became obliterated and an abnormal proliferation of vascular tufts ensued. The typical endothelial buds appeared consistently, but only rarely did detachment occur. Patz found that the more immature the retinal vessels were, the more susceptible they were to these changes produced by oxygen. All of the other organs of the animals treated with oxygen were normal. If concentrations of less than 40 per cent oxygen were employed, retinal vasoconstriction and obliteration did not occur; and if the animals were kept in an oxygen environment of only 14 to 15 per cent (normal oxygen in the ordinary room is 20 per cent), none of the changes of retrolental fibroplasia were produced.

Since oxygen was first implicated in 1952, eighteen of the major institutions in this country have been carrying on a cooperative clinical study on its role in this disease. In this study, as reported by Kinsey at the recent meeting of the American Academy of Ophthalmology and Otolaryngology, all infants weighing less than 1,500 Gm. were carefully followed. One group received 50 per cent oxygen, and a similar group received curtailed or no oxygen. In the group which received routine oxygen, 72 per cent developed retrolental fibroplasia, while in the curtailed group only 30 per cent developed some stage of active retrolental fibroplasia. Perhaps of more significance, 25 per cent of the group exposed to routine oxygen showed some residual form of the disease, while in the curtailed group only 6 per cent had cicatricial forms. The statistics compiled from this cooperative effort raise the question of whether the incidence of the disease varies inversely with the birth weight. The fact that the incidence increases rapidly with each additional day on oxygen for the first 10 days suggests that the probability of occurrence of the disease is not based on the infant's weight at birth or other factors such as illness; rather, the disease occurs as a result of the child's direct exposure to oxygen. The investigation would suggest that there may be a critical concentration of oxygen at approximately 50 per cent; this fact was not definitely established, however. The rate of withdrawal from oxygen did not appear to be a factor in producing the retrolental fibroplasia.

These clinical and experimental data justify the recommendations that all concerned with the care of premature infants should be alerted to the dangers of exposing the babies to oxygen and that oxygen therapy should be rigidly curtailed in the nurseries where these infants are kept. Irregular or periodic respiration is no longer considered an indication for the use of oxygen; and in those instances when oxygen may be life-saving and necessary, its concentration in the incubator should be less than 40 per cent and the infant should be removed from the increased oxygen as soon as his condition permits.

As a routine, it has been our practice to examine all premature infants by the end of the first week of life. This is accomplished by removing the child from the incubator after the pupils have been dilated with one drop of 2 per cent homatropine and one drop of 10 per cent Neo-synephrine. If one recalls that the vitreous is frequently hazy in premature infants; that the disk appears grayish or white; that occasionally remnants of the hyaloid system are still present; and that the retinal periphery has a grayish, homogeneous color and appears elevated, he will not confuse these findings with those of retrolental fibroplasia. Examinations are carried out weekly while the infant is in the hospital and biweekly for three months thereafter. If the fundus remains normal for this length of time, we may be sure that the infant will not develop retrolental fibroplasia. If retrolental fibroplasia is suspected, the eyes should be re-examined every few days; but it is wise in the early stages of the disease not to tell the parents, for regression is the most likely course. In the active stage of the disease, the pupils should be kept dilated to prevent synechiae. If the disease does not progress beyond Grade II, normal vision may be anticipated. If Grade III ensues, one may predict a vision of somewhere between 3/200 and 10/200. Grades IV and V of this condition reduce the vision to light perception. The most frequent complication is secondary glaucoma, which develops in one-third to one-fourth of the cicatricial cases. Here blindness is usually present, and the only therapy indicated is the use of miotics. Only rarely does pain necessitate a filtering operation. Buphthalmus rarely develops because the secondary glaucoma is usually transitory. The cause of the glaucoma is the shallow anterior chamber, and corneal opacities frequently result from anterior synechiae. Cataract is rare, appearing in about 3 per cent of cases; but esotropia of the more amblyopic eye is common. The retinal folds or partial detachment which may be present tend to remain stationary.

It is estimated that some 5,000 children have been blinded by this disease. Let us hope that by utilizing the knowledge which has been gained and discovering still more about the etiology of this disease, we may soon effectively prevent the development of retrolental fibroplasia.

122 South Michigan Boulevard.

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BASIC SCIENCE EXAMINATION

The next examination given by the Wisconsin State Board of Examiners in the Basic Sciences will be on Saturday, May 14, from 8:00 a.m. to 5:00 p.m. at the Hotel Schroeder, Milwaukee. Friday, May 6, is the last filing date.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

What important effect, formerly disregarded, must nowadays be carefully considered in evaluation of a new therapeutic agent?

Carefully performed studies of the relief from symptoms afforded by placebos have furthered the impression that evaluation of the placebo response is mandatory in the investigation of all new drugs if the effect on subjective symptoms as well as objective findings is to be determined. L. Lasagna, F. Mosteller, J. M. von Felsinger, and H. K. Beecher, of the Harvard Medical School, observed 162 postoperative patients for their ability to obtain significant relief from pain with subcutaneous injections of placebo and of morphine. Patients were divided into those who obtained relief from placebo (reactors) and those who did not (nonreactors). Placebo reactors had a significantly higher incidence of relief with morphine than nonreactors. Morphine and placebo were less effective analgesics in patients with persistent pain than in those with pain of short duration. Less than half the patients who received multiple doses of placebo responded consistently to the placebo.

There was no sex difference and no difference in intelligence between reactors and nonreactors. Significant differences in attitudes, habits, educational background, and personality structure between consistent reactors and nonreactors were demonstrated by personal interviews, questioning of nurses, Rorschach psychodiagnostic tests, thematic apperception tests, and the Wechsler–Bellevue Scale intelligence quotient. Placebo reactors had less pain; asked for medication less often; and were more anxious, more self-centered and preoccupied with internal body processes, and more emotionally labile than nonreactors. Reactors were more dependent on outside stimulation than on their own mental processes, which were less mature than in nonreactors. Reactors were more labile and outwardly oriented and could relieve their tension and anxiety more easily than nonreactors. The latter were more rigid and emotionally controlled. Reactors and nonreactors are definite recognizable types, but they are differentiated only after extensive psychologic testing and not by casual observation.

These investigators hypothesized that there is a certain psychologic set which predisposes to anticipation of pain relief and thus to a positive placebo response. Presence of the traits making this set is probably not an all-or-none phenomenon but rather a graded one. Other factors (such as severity of pain) also affect the response to inert agents, and the resultant of these factors, psychologic and nonpsychologic, known and unknown, determines whether a particular dose of placebo produces an effect in a given patient.

Thus, it appears that in the preliminary investigation of a new drug on a population, an evaluation of the magnitude of the likely placebo response must be made.—HARRY BECKMAN, M. D.

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THE MEDICAL FORUM

BLUE SHIELD TO STUDY RELATIONSHIP WITH LOCAL PLANS

Commission Approves "Special Services" Contract Plans

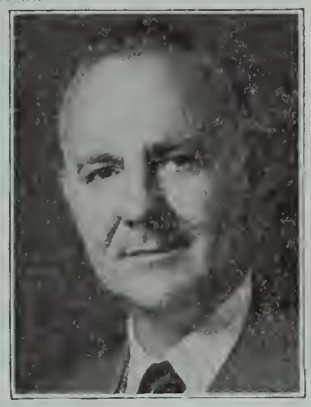
Madison, March 12.—Final approval has been given by the State Society's Commission on Prepaid Plans to the development of a "special services" contract to provide extra benefits for Blue Shield subscribers.

Under the new contract, a subscriber who has the basic program of Blue Shield would be able to purchase a "special services" contract which will provide benefits for x-ray therapy, dental surgery, and first-aid medical and surgical care for the newborn on a full-payment basis.

Additional benefits for diagnostic x-ray and laboratory procedures and home and office medical care would be available on an indemnity basis at the option of the purchaser.

The Commission met March 12–13 in Madison. At the meeting, Dr. R. E. Garrison, Wisconsin Rapids, was named to be the voting delegate at the 1955 Annual Conference of Blue Shield Plans in Chicago.

A special experimental effort in coverage for migrant workers was authorized for 1955. It is hoped that Blue Shield and Blue Cross will be able to devise some type of coverage for these workers prior to their arrival this spring. It is believed that such a program would have significant value to the community, migrant workers, physicians, and hospitals alike.



Dr. Garrison

Deductible-type contracts for Blue Shield protection received considerable discussion by the Commission. There is a growing belief among the public that a deductible contract offers some relief from increasing premium costs. The problem facing the Commission, however, relates to the matter of retaining the full-payment features of the Blue Shield contract while at the same time incorporating the deductible idea.

In an attempt to retain the full-service feature of Blue Shield, while using the deductible as a means of lowering the premium, the Commission has approved an arrangement whereby Blue Shield will pay the entire benefits to the physician and then bill the employer for the total amount of all deductible items paid for his employees during the month. The employer reimburses Blue Shield for the deductible amount and, in turn, collects from the employee.

Any other arrangement offering the deductible feature must be offered through the identification of Physicians Indemnity Plan, according to the Commission. This is necessary, the Commission said, because no other deductible arrangement seems to offer a possibility of retaining the full-payment principle.

Chicago, March 24.—A Wisconsin proposal calling for a comprehensive study of the relationship between the national Blue Shield organization and the individual member plans received the unanimous approval of the delegates to the national meeting of Blue Shield Medical Care Plans, held in Chicago, March 20 to 24.

With a registration of more than 450 representatives of Blue Shield and Blue Cross, the 1955 annual conference of member plans throughout the country brought together programs and business sessions of major consequence to the future of the Blue Cross–Blue Shield movement. Important discussions concerned control of local plans, enrollment of national accounts, physician responsibility in plan direction, and the future of wholly-owned insurance subsidiaries.

WISCONSIN PROPOSES STUDY

The proposal initiated by the Wisconsin Physicians Service delegation was designed to provide an immediate evaluation of the extent to which the national Blue Shield organization should control or direct individual plans throughout the country.

(The resolution offered by the Tenth District, incorporating the Wisconsin proposal, is reported in full in the Blue Shield Page of this issue of *The Journal*.)

The Blue Shield Commission, itself, proposed that the plans adopt the principle that any project undertaken by the national organization and receiving approval of 75 per cent of the plans become mandatory for all plans. The proposal provoked an undercurrent of discussion throughout the meeting. The reference committee recommended that it should not be acted upon, however, because it was not presented as a constitutional amendment.

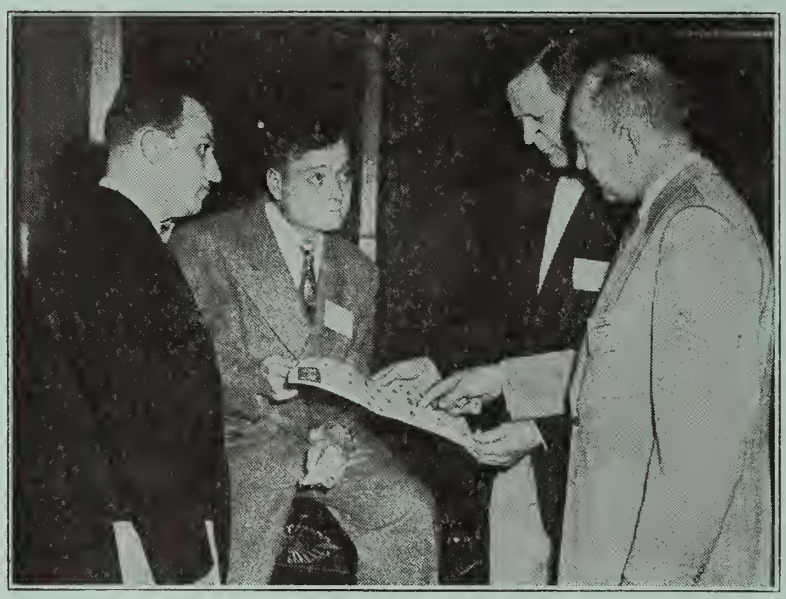
Much of the business and program time of the conference was occupied with the problem of enrolling national accounts under various forms of uniform contracts

(Continued on page 216)

Arrest Director of Antivivisection Group

Chicago, March 17.—On his first day back from a Caribbean cruise, Clarence E. Richard, 55-year-old founder and managing director of the National Antivivisection Society, was arrested and charged with embezzlement of $8,000 from the society.

According to Chicago newspapers, Cook County (Ill.) States Attorney John Gutknecht said that Richard took the embezzled funds for his personal use. Richard termed the charge "ridiculous" and said "it will have to be proved."



Dr. James F. Maser, Rice Lake, (far right) discusses SMS First Aid Wall Chart with (l. to r.) W. G. McVay, Kansas City, Mo.; Dr. J. S. Wyatt, Pocatello, Idaho; Dr. Carroll Andrews, Sonoma, Cal., at National Rural Health Conference in Milwaukee in February.

AMA Publishes Book Of 1954 Film Reviews

Chicago, March 11.—The Committee on Medical Motion Pictures of the AMA has announced the availability of Booklet No. 6 of Reviews of Medical Motion Pictures. The book contains 64 critical reviews of medical and health films published in *The Journal* of the AMA in 1954.

The Reviews provide a convenient reference source for society and hospital program chairmen. The Committee also publishes yearly a list of films available through the AMA Film Library and also a booklet listing other sources for obtaining films for both professional and lay groups.

County medical societies may obtain copies from the Committee. Other requests should be directed to the Order Department, American Medical Association, 535 N. Dearborn St., Chicago 10, Ill. Individual books are 25 cents.

Legislature Honors Wisconsin Physician

Madison, March 1.—The Wisconsin Legislature paid tribute to the life-long public service of the late Dr. Joseph H. Hardgrove of Shawano, in a resolution passed jointly by the Assembly and Senate.

The resolution, introduced by Assemblymen Robert Marotz, Shawano, and Nicholas Lesselyoung, Fond du Lac, was adopted as a "token of esteem" for Dr. Hardgrove's "four score years of fruitful living." Dr. Hardgrove died in November, 1953, at the age of 82.

Dr. Hardgrove's distinguished career in both the medical and teaching fields was cited in the resolution. Graduating from Oshkosh State Teachers College in 1903, he taught school in Tigerton and helped organize the Tigerton High School of which he became principal.

He subsequently entered Marquette University School of Medicine, receiving his M. D. degree in 1916. He practiced in Eden until his retirement in 1949. A life member of the State Medical Society, he was also a member of the Fond du Lac County Medical Society. He was president of the Fond du Lac County Rural Normal School Board for more than 10 years and served as an assemblyman from the second Fond du Lac district in the 1933 legislature.

PIERCE–ST. CROIX GROUP SPONSORS AREA SCHOOL HEALTH CONFERENCE

River Falls, April 5.—Development of an active program of health care through local schools was a major topic of discussion at the school health conference sponsored by the Pierce–St. Croix County Medical Society on April 5 at Wisconsin State College in River Falls.

A crowd of more than 200 people took part in the meeting.

Cooperating with the Society in presenting the 1-day meeting were the Pierce–St. Croix County Dental Group, the county and city school systems, and District Seven of the State Board of Health. Patterned after the regional conferences sponsored by the State Medical Society and the School Health Council, the meeting emphasized area problems and encouraged local coordination of efforts between health and school personnel and parents.

The conference is one of several public relations projects initiated by the Society to establish the medical profession as leaders in public health improvement in the county.

Featured speaker at the conference's morning general session was Dr. E. S. Gordon, Madison, of the University of Wisconsin Medical School. The afternoon session was divided into five panel discussion groups covering health examinations, mental health, referrals, physical education, and nutrition. The nutrition discussion reviewed the recently completed resurvey of food habits in Pierce and St. Croix counties.

Representatives of the Division on School Health of the State Medical Society, the State Board of Health, the State Department of Public Instruction, and the Wisconsin Interscholastic Athletic Association acted as special consultants for the meeting. Panel participants included professional and public health people, educators, and parents from the two counties.

PHYSICIANS PARTICIPATE

Physicians on the program included: Drs. Rex Graber, Chippewa Falls; Philip Gutzler, River Falls; Frank Springer, Elmwood; J. H. Armstrong, New Richmond; H. A. Dasler, Amery; Albert A. Lorenz, Eau Claire; Philip W. Limberg, Glenwood City; and C. A. Olson, Baldwin. Dr. Joseph Healy, New Richmond, president of the Pierce–St. Croix Society, presided.

Dr. Olson was chairman of the committee arranging the conference. Working with him were Drs. M. G. Anderson, Hudson, and C. W. Horswill, River Falls.

REVIEW POLICIES OF HOSPITAL ACCREDITATION

The policy decisions and rulings of the Joint Commission on Accreditation of Hospitals affect the entire medical profession generally and, in particular, the officers of hospital medical staffs and departments. In recent months, the Commission has announced its policies in regard to a number of specific questions such as eligibility for accreditation, "dry runs," required consultations, and status of chiropodists.

ELIGIBILITY FOR ACCREDITATION

In order to be eligible for a survey for accreditation, a hospital must meet the following criteria: 1. It must be listed in the Administrator's Guide issue of *Hospitals*, published by the American Hospital Association; 2. It must have at least 25 beds; 3. It must have been in operation at least 12 months.

Previously, the Commission used registration by the American Medical Association as a criteria for survey. Since the A.M.A. discontinued its hospital registration program, in view of the work of the Commission, the Commission has adopted the criteria of listing by the American Hospital Association. Membership in the Hospital Association is not a requirement for listing.

"DRY RUNS"

The Commission receives many requests for "dry runs" by hospitals to see if they are ready to be accredited. The Commission has neither the funds nor the field surveyors necessary to accommodate these requests. In addition, the Commission must meet pressing demands for initial surveys as well as re-surveys of provisionally accredited institutions.

Many hospitals also request specific surveyors for their institutions. The Commission makes every effort to consider the local problems of a particular hospital but purposely rotates its field representatives so that charges of favoritism and discrimination can never be leveled at surveyors for the Commission. Specifically, the Commission rotates surveyors so that they do not return to any one state for several years.

The question has also been raised concerning how long a hospital may stay provisionally accredited. It is the policy of the Commission that if a provisionally accredited hospital continues on the provisional list after the second survey, it will be surveyed a third time the following year. If it again fails to meet the standards for accreditation, it will be dropped to No Accreditation.

REQUIRED CONSULTATIONS

In December, 1954, the Commission amended its Standard on Consultations to read as follows: "Except in emergency, consultation with another qualified physician shall be required in all first Caesarean sections and in all curettages or other procedures by which a known or suspected pregnancy may be interrupted. The same requirement shall apply to operations performed for the sole purpose of sterilization on both male and female patients. Included in consultations required under this Standard are all those which are required under the rules of the hospital staff."

The Standard also considers consultations appropriate in major surgical cases in which the patient is not a good risk and in all cases in which the diagnosis is obscure or when there is doubt as to the best therapeutic measures to be utilized. The Commission states that judgment of the necessity of consultation rests with the physician in charge but that it is the duty of the executives of the staff to see that members do not fail to call for consultants as needed. In addition, the consultant must be well qualified to give an opinion in the field in question.

The Standard says: "A satisfactory consultation includes examination of the patient and the record and a written opinion signed by the consultant which is made part of the record. When operative procedures are involved, the consultation note, except in emergency, should be recorded prior to operation."

STATUS OF CHIROPODISTS

The Commission will not penalize a hospital for granting privileges to a chiropodist. A hospital staff may vote a chiropodist privileges but must evaluate the chiropodist applying and must set up qualifications, rules, and regulations.

Chiropodists must be under the jurisdiction of the department of surgery. A physician must be in attendance when the chiropodist performs in the hospital on an inpatient though physician attendance is not required for minor outpatient podiatry. However, such service is under the general supervision of the surgical department.

The chiropodist is in the nature of a technician and is not qualified to write the history or physical examination or to check the heart and lungs before an anesthetic. This also applies to prescribing drugs. These functions must be performed by a physician on the staff or with privilcges in the hospital and the patient must be admitted under the physician's name.

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Medical Education Fund Receives Strong Wisconsin Support

Chicago, March 8.—Over 600 Wisconsin doctors contributed their support to medical education in 1954, according to the annual report published by the American Medical Education Foundation.

AMEF figures report that a national total of $3,006,197.78 was contributed by 57,578 members of the medical profession during the year. Wisconsin's share was $44,744.88, ranking tenth in state contributions for the whole country.

Of the 628 Wisconsin contributors, 145 gave $4,661.00 directly to the Foundation. The remaining 483 doctors gave $40,083.88 directly to the nation's 80 approved medical schools. The number of Wisconsin contributors ranked nineteenth in the country.

Nationally, $1,181,928.63 was given to AMEF and $1,824,269.15 was contributed directly to the medical schools.

Direct individual contributions to the two Wisconsin medical schools in 1954 totaled $84,766.48. Marquette University School of Medicine received $81,341.48 from 764 physicians throughout the country. The University of Wisconsin Medical School was given $3,425.00 by a total of 50 doctors.

New Guide Tells Opportunities in Health Careers

Madison, March 15.—Publication of a comprehensive Health Careers Guidebook, giving vocational information on 156 different health occupations, has been announced by the National Health Council.

Designed for high school students and vocational counselors, the 160-page book is being distributed to all of the country's secondary schools and junior colleges. The Wisconsin Public Health Council is cooperating in encouraging the wide distribution and use of the guide and other health careers information in the state.

In each of the occupations covered, the book gives authoritative and up-to-date information on type of work, educational requirements, opportunities, and other aspects of the field. Each occupational area has been reviewed by the appropriate organization and carries its name as a source of further information. In addition, the book was pretested in 30 schools by students and educators.

Prepared by the National Health Council as the first step in a Health Career Horizons Project, the guide is designed not only to provide vocational information, but to encourage students to enter the health services field. The Council is also planning to issue a suggested outline for community action to help interested communities guide and develop Health Careers programs to meet their local needs.

BLUE SHIELD . . .

(Continued from page 213)

and rates. Declaring that the buyer for a national account "wants uniformity—he has to keep cost figures—he wants uniformity of equipment for a given job," Lewis G. Hersey, executive director of the Medical Service Bureau of the Utah State Medical Association, urged that "every plan should have a contract available that will meet the requirements for sale nationally."

MUST MEET PUBLIC NEEDS

Discussion led to the adoption of a resolution by the plans pointing out the desirability of meeting public needs and demands through doctors' plans under which there is maintenance of free choice of physician and a high standard of service.

The resolution urged the organizations to cooperate in the successful writing of national accounts even though it may involve some sacrifices by the medical profession in accepting the necessity of a certain degree of uniformity. All plans were urged to unite in developing a uniform type of contract so far as the nature of benefits is concerned.

Several resolutions recognizing the responsibility of physicians in the direction of Blue Cross and Blue Shield programs were introduced and were held over for action next year. One resolution called for an amendment providing that the president, president-elect, and vice-president of Blue Shield Medical Care Plans, Inc., "shall be doctors of medicine."

Another resolution, offered by Dr. J. W. Fons of Milwaukee, would require that district members of the Blue Shield Commission, the organization's board of directors, be elected to hold office for three years rather than one as at present.

Attention was given to the future of wholly-owned insurance subsidiaries, specifically Health Service, Inc., an insurance company wholly owned by Blue Cross, and Medical Indemnity of America, a similar company wholly owned by Blue Shield. Dr. Carll S. Mundy, Columbus, Ohio, presented the report of a committee on rating for the two companies.

PLANS TO GET FULL REPORT

In the report, he asked reactions to proposals that Blue Shield plans consider writing the basic contracts of MIA and give full consideration "to the development of a uniform service benefit income level and uniform scope of benefits to be used by HSI–MIA for those national accounts with employees residing only in service plan areas."

The conference delegates directed that the full report of the committee be sent to each Blue Shield plan with the request that it consider whether it is able to implement any one or more of the recommendations of the committee.

James O. Kelley, executive secretary of Surgical Care of Milwaukee, was re-elected as treasurer of the Blue Shield Commission during the meeting. Dr. Norman A. Welch, Boston, was elected president of the group; Dr. Francis T. Hodges, San Francisco, vice-president; and Dr. Dwight V. Needham, Syracuse, secretary.

Blue Shield Names New Director to Head Commission

Chicago, March 1.—The appointment of John W. Castellucci as executive director of the national Blue Shield Commission has been announced by Dr. L. Howard Schriver, Cincinnati, president of the Commission. Castellucci has been serving as acting director of the Commission since the resignation of Frank E. Smith as director.

Formerly assistant director of Michigan Medical Service, the Michigan Blue Shield plan, Castellucci has been with Blue Shield since 1943. He helped establish the Veterans' Home-Town Care Plan and has been active in Blue Shield organization and operation, particularly in guiding the physician relations program of the Commission.

MADISON M. D. GIVEN AWARD AT STATE HOSPITAL MEET

Milwaukee, March 17.—Dr. Harold Coon, superintendent of University Hospitals at Madison, received the Award of Merit from the Wisconsin Hospital Association at its annual meeting in Milwaukee, March 17.

The award cited his competence as an administrator and a leader on hospital administrative problems in state and national circles. "Wherever he has served, he has performed his task with distinction," the award read. Dr. Coon is a member of the Board of Directors of the American Hospital Association.

Dr. Arthur J. McCarey, Green Bay, president of the State Medical Society, told nearly 400 hospital people attending the conference that "hospital boards shouldn't tell the medical staff how to practice medicine, but doctors have a distinct responsibility to provide good medical care."

Dr. Harold Coon, left, superintendent of University Hospitals, Madison, receives annual Award of Merit from Wisconsin Hospital Association, presented by Joseph G. Norby, former administrator of Columbia Hospital, Milwaukee. Award was presented during a luncheon at the Association's annual meeting in Milwaukee in March.

NEED PHYSICIANS' COOPERATION

He pointed out that the hospital board is responsible for the operation of the whole hospital and that it must work closely with physicians to assure the highest quality care. He pointed out that an accredited hospital can help the physician in his search for a place to practice good medicine.

Dr. James Conley of the medical staff of Columbia Hospital in Milwaukee, explained what the physician expects from the hospital in the way of patient care. He felt that, as a general rule, registered nurses spend too much time in administrative duties rather than attending patients. The patient resents the lack of care he receives in the modern hospital from the registered nurse whom he has been educated to believe should provide personal care for him.

CONSIDER LOCAL PROBLEMS

Considerable discussion centered around problems of accreditation and particularly the number and type of medical staff meetings which must be held in order to achieve and hold an accredited status. Dr. Kenneth B. Babcock, Chicago, director of the Joint Commission on Accreditation of Hospitals, pointed out that the commission has established a policy of treating each hospital's local problem separately in deciding whether it meets appropriate standards for accreditation.

He urged medical staffs having problems in getting accreditation to contact his office so that special consideration can be given to problems peculiar to a local situation.

Magazine Reports Cost Of Medical Care Today

An informative article on "What It Costs People to Be Sick," detailing some favorable information on doctors' fees, appeared in the December 24, 1954, issue of *U.S. News & World Report.*

Quoting figures "based on the latest study of the Social Security Administration, brought current through estimates by the Economic Unit of *U.S. News & World Report,*" the article said that physicians' fees used to account for 30 per cent of the out-of-pocket cost for medical care; now they are 29 per cent.

"Dental bills," the article stated, "are less than 10 per cent today, compared with more than 12 per cent in 1948.

"These fees tend to stay fairly constant for periods of years. The last big jump came during World War II. Today many physicians are charging the same for office calls and sickroom visits as they did shortly after the war."

The story pointed out: "Government experts attribute most of the rise in hospital expense to higher charges resulting from better pay scales for hospital workers and the higher cost of food.

"Dentists and physicians, on the other hand, are getting a somewhat smaller share of the nation's private medical outlays. This finding runs counter to criticism of physicians' fees."

The report said that medical care is costing people a total of 12.4 billion dollars a year, of which 2.1 billion is met through health insurance.

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Institutes Outline Hospital Program For Prematures' Care

Milwaukee, March 31.—The second in a series of special institutes on medical and nursing care for premature infants, sponsored by the Society's Division on Maternal and Child Welfare, was held at the Milwaukee Hospital Maternity Pavilion on March 30 and 31.

A third clinic is scheduled for April 13 and 14 at St. Mary's Hospital in Madison. The first clinic was held at the Milwaukee Hospital, March 23–24.

Designed to provide the latest information on prematurity, the clinics are based on a team approach for coordination of care in the individual hospital. Each team consists of a doctor and a nurse who supervise the care of all prematures in the hospital.

The doctor, designated by the medical staff, is responsible for directing medical care in cooperation with the family physician. The nursery care of the infants is under the direction of the nurse who, together with the doctor, receives special training in the operation of such a program at the institutes.

The program of the meetings includes discussions of obstetrical problems relating to premature births; management of physiological handicaps and disease problems; care, feeding, and nursery management; and demonstrations of facilities and techniques.

NAME PARTICIPATING HOSPITALS

The Milwaukee Hospital institutes are under the direction of Dr. K. J. Winters, Milwaukee, and Miss Betty Petersen of the nursing staff. Directing the Madison institute are Drs. T. V. Geppert and C. E. Hopkins of Madison, and Sister Mary Dorine, nursing supervisor of St. Mary's Hospital.

The following hospitals have sent teams to the Milwaukee clinics: Sheboygan Memorial; Mount Sinai, Evangelical Deaconess, St. Michael's, St. Mary's, and Milwaukee County General, Milwaukee; St. Joseph's, Hartford; Langlade County Memorial, Antigo; Community, New London; St. Agnes, Fond du Lac; Trinity and St. Joseph's, both of Ashland; St. Mary's, Rhinelander; Platteville Municipal; and Luther, Eau Claire.

Teams scheduled to attend the Madison institute in April represent these hospitals: St. Clare, Monroe; Stoughton Hospital; Divine Savior, Portage; Waupun Memorial; St. Joseph's, Superior; Holy Family, New Richmond; St. Mary's, Columbus; Two Rivers Municipal; and St. Joseph's, Beaver Dam.

Concerning the School Vision Screening Program

In 1952, a special committee of the Section on Ophthalmology and Otolaryngology of the State Medical Society was formed. This group was set up to act as a liaison committee with a similar group representing the Wisconsin Optometric Association. Their purpose was to attempt a solution of the problems involved in developing visual screening programs in the school systems of Wisconsin.

Work of these committees resulted in "An Outline to Facilitate the Development of a School Vision Screening Program." This outline was accepted by the Section on Ophthalmology at its meeting in October, 1954, and has been approved by the Society's Commission on State Departments and its Division on Visual and Hearing Defects as well as the Council of the State Medical Society.

The outline has been unanimously accepted by the Wisconsin Optometric Association.

In the accompanying outline, it is urged that particular attention be paid to Section II, parts A and B, concerning organization and development. It is felt that, without the establishment of a properly constituted planning committee and a continuing advisory committee under the stimulus of the public health nurse and the district health officer, the recommendations cannot be successfully carried out.

Society Endorses Plan For Assistants' Group

Madison, March 1.—The State Medical Society gave its endorsement and support to plans for creating a state-wide society of medical assistants when the Council on Medical Service approved a proposed Constitution and By-laws for the Wisconsin Medical Assistants Society.

The Constitution was prepared by members of the Dane County Medical Assistants and the Milwaukee County Medical Assistants, which have taken the lead in organizing a state group. A close working relationship with the State Medical Society was requested. The Council on Medical Service will act as an advisory committee for the proposed group.

To establish the state group, an organizational meeting is planned for early June for medical assistants throughout Wisconsin. At that time, the proposed Constitution and By-laws will be submitted for approval and officers will be elected. Letters concerning the meeting will be sent to each Wisconsin doctor and his assistants.

According to the Constitution, a member of the Society could be "any eligible person actively employed in the office or laboratory of a member of the State Medical Society, and those employed in a teaching, technical, or administrative capacity in medical hospitals accredited by the AMA, and medical laboratories in the State of Wisconsin."

The group would be nonprofit, organized for social and self-improvement purposes.

In addition to the Dane and Milwaukee County Societies, there are medical assistant groups in Fond du Lac and Wausau. There are seven state organizations.

Quotation Marks . . .

"Everyone who comes in contact with doctors learns to recognize the dignity of medicine. The dignity of medicine is closely akin to what we mean by the essential dignity of man. As physicians we can never afford to lose sight of the individuality and personality of every patient we see. This is our tribute, paid daily, to the dignity of man. It is reflected back on us in the high regard that our patients have for the ultimate dignity of medicine."—Dr. Justus Ohage, past president, Minnesota State Medical Association.

An Outline to Facilitate the Development of a

SCHOOL VISION SCREENING PROGRAM

(Approved by the Commission on State Departments, December 16, 1954.
Approved by the Council, February 27, 1955.)

I. PURPOSE:

To detect significant visual defects among school children.

II. ORGANIZATION AND DEVELOPMENT:

A. Planning Committee:
1. Public Health Nurse: County, City or School Nurse.
2. Health Officer: District, County or City Health Officer.
3. County Medical Society:
   a. One member of The Executive Committee.
   b. Ophthalmologists.
   (If no ophthalmologist is available locally, one from another county or city could serve.)
4. Area Optometic Society:
   a. Optometrists.
5. School Representatives:
   a. Superintendent or Principal.
   b. Teachers.
6. Parent Representatives:
   a. Parent Teacher Association.
   b. Health Council.
7. Other interested persons.

B. Continuing Professional Advisory Committee: To select tests, to establish standards, and to evaluate the program as it continues.
1. Public Health Nurse.
2. Ophthalmologists.
3. Optometrists.

C. Screening Methods:
1. Selection of the vision test or tests to be used: (It is emphasized that no specific test is foolproof. Good results depend upon intelligent administration of the tests and careful interpretation of the findings.)
   a. Snellen test charts—equipped with a source of standard illumination. (Time-tried and satisfactory means of testing visual acuity for distance.)
   b. Acceptable mechanical devices for screening purposes may be used by adequately trained personnel. The results of these tests should be realistically evaluated to avoid over-referral:
      (1) Massachusetts Vision Test.
      (2) American Optical Company Sight-screener.
      (3) Keystone Telebinocular.
      (4) Bausch and Lomb Orthorater.
2. It is suggested that, as an additional part of the screening procedure in testing distance visual acuity, a pair of plus 2.00 D. Spheres be placed before the eyes to reveal high degrees of hyperopia. However, referral on this basis alone must be carefully evaluated to avoid over-referral.
3. The value of tests for color vision, heterophoria, and stereopsis, as applied to school vision screening programs, is doubtful.
4. Grades to be screened:
   a. Annual vision screening of school children is recommended. It is suggested that, as a minimum program, grades one, four, and seven, as well as all new pupils in the school and those observed by the teachers as possibly having visual defects, be screened annually. The vision testing program can conveniently be synchronized with the hearing screening program.

III. ADMINISTRATION:

A. A Director of the program should be named by The Planning Committee. It is recommended that the Director not be an optometrist or a physician.

B. The teacher or volunteer lay women, trained by the Continuing Professional Advisory Committee and/or the Public Health Nurse under the direction of the Committee, to administer the initial vision screening tests.

C. Public Health Nurses, or especially trained and proficient lay persons to recheck children who fail initial tests.

D. All children having unsatisfactory vision tests, as well as those having significant visible eyelid or ocular defects, to be referred for further eye examination and refraction.
1. Form letter to parents of the child with a visual defect advising further examination by an eye doctor. This letter should include space for the recording, by the examining doctor, of his recommendations. This letter, with the recommendations of the eye doctor added thereto, is to be returned to the Director of the program.

E. Follow-up letters and visits by the Public Health Nurse if the referral recommendation is ignored.

F. Liaison between Public Health Nurse and classroom teachers.

IV. EMPLOYMENT OF SPECIAL FUNDS TO FACILITATE THE PROGRAM:

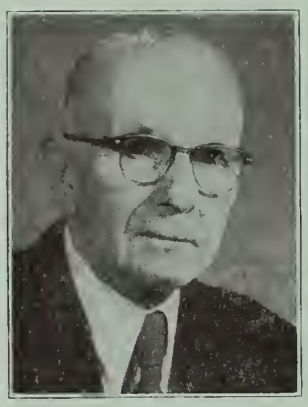
A. The interest of service clubs and of other private organizations may be sought.

B. Uses of such funds:
1. Purchase of screening test equipment.
2. Clerical, stationery, and mailing costs.
3. Financial aid for professional fees and glasses in needy cases.

50-YEAR DOCTORS RECEIVE SOCIETY LIFE MEMBERSHIPS

Madison, March 1.—The Council of the State Medical Society has granted life memberships to Drs. Maynard H. Fuller, Green Bay; James V. May, Marinette; and Walter W. Stebbins Madison.

The honor was given to the doctors in recognition of their years of service to medicine and public health in Wisconsin, upon their completion of 50 years' continuous membership in the State Society. All are members of the Society's 50-Year Club, created for physicians who have been in practice for a half-century.



Dr. Fuller

A graduate of Marquette University School of Medicine in 1904, **Dr. Maynard H. Fuller**, Green Bay, specializes in ophthalmology and otorhinolaryngology. He has taken postgraduate work in this field in Chicago and New York and spent a year at the Charitable Eye, Ear, Nose, and Throat Clinic in Berlin, Germany.

Active in the Brown–Kewaunee–Door County Medical Society, Dr. Fuller has served as president and as secretary of the group. He was born in Sharon in 1882 and practiced in Angelica and Bonduel before coming to Green Bay.

A graduate of Bellevue Hospital Medical College in 1898, **Dr. Walter W. Stebbins**, Madison, has practiced in Green Bay, Mount Vernon, and Verona.

Dr. Stebbins

He has been a general practitioner in Madison since 1916. His son, Dr. George G. Stebbins, is associated with him in practice.

Dr. Stebbins has been an active member of the Dane County Medical Society, having a continuous membership of over fifty years. He is also a member of the American Geriatrics Society.

He was born in Little Falls, New York in 1874.

Dr. May

Dr. James V. May, Marinette, graduated from the College of Physicians and Surgeons at St. Louis Mo., in 1900. After practicing in Wautoma and Redgranite, he located in Marinette in 1906 where he has specialized in ophthalmology and otorhinolaryngology.

He took postgraduate work at Illinois Medical College and in England and Austria and was certified by the American Board of Ophthalmology in 1925.

Dr. May was twice president of the Marinette–Florence County Medical Society, once for a 10 year period. He is also a member of national and state e.e.n.t. specialty groups.

He was born in 1876, in Russell, Iowa. His son, Dr. G. A. May, practices in Des Moines, Ia.

DR. RAINE RENAMED TO BOARD OF HEALTH

Madison, March 1.—Governor Walter Kohler recently appointed Dr. Forrest Raine, Milwaukee, to membership on the State Board of Health.

The appointment is for a term ending in February, 1961. Dr. Raine has been a member of the board since 1947.

Study Estimates Amount Of M. D. Charity Work

What is the dollar value of the free medical care and treatment which the country's physicians provide daily?

One of the few studies made on this question was recently completed by the New Hampshire Medical Society. The society found, in a survey of general practitioners and specialists, that somebody, somewhere in New Hampshire gets $4 worth of free medical care and treatment every minute.

Annual value of this free medical care is $2,096,640, according to the society. It pointed out that almost all practicing physicians do some charity work and added: "The scope of this depends upon the doctor's geographical location, the economic status of the patients in his area, and the type of professional service rendered."

In another study, made by Dr. James Tyner, Newark, N. J., several years ago, it was estimated that the average doctor spends 12 per cent of his working hours doing charity work.

Rural County Sets Up Emergency Call System

An emergency call system tailored to fit the needs of a relatively small rural county was recently established in Wyoming County, Pa. The call system centers around the county's one hospital which has approximately 40 beds.

Nine physicians serve the county's population of about 20,000 people, scattered mostly in rural sections over an area of 396 square miles. Under the system, one doctor is always on call at the hospital, assigned to a weekly tour of duty. The hospital superintendent sets up the rotation of doctors on call and reminds them several days in advance of their week of duty.

The public is instructed to contact the hospital for the name of the doctor on call. In addition, the doctor's name is supplied to the state police barracks in the county so that the police can contact him directly.

County physicians have also established reciprocal working arrangements so that outlying districts are always covered. Posters give the system publicity.

New Horizons in Psychiatry*

By FRANKLIN G. EBAUGH, M. D.**
Denver, Colo.

Introduction

IT HAS become increasingly clear that the State of Wisconsin is forging ahead as a leader in progressive medicine and in progressive medical legislation. This new diagnostic center is something of which the state, the legislators, and the medical fraternity can indeed be proud. Statistics tell nothing of the need to serve, the unselfish power of direction, the unified drive of a community to obtain the ideal public and community service. The new diagnostic center provides an excellent example of something which I feel is needed in every medical center. What you have here in Wisconsin is a hospital designed for relatively short periods of observation of men, women, adolescents, and children. The patients present psychiatric and behavior problems; and the diagnostic center provides facilities whereby, over a short period of time, intensive psychiatric study can be conducted on each case and recommendations made concerning care and treatment.

I have been given specific data concerning the diagnostic center, and such data make interesting reading. Eligibility for admission to the hospital is limited by law to patients who have already been committed to the State Department of Public Welfare, which has a Division of Mental Hygiene, along with divisions of correction, children and youth, public assistance, and business management. The purpose of this diagnostic center, as originally intended, was to strengthen the services to children and youth in the state. Its development will be along the lines of building up a high-quality service to enrich the treatment program in this state and the educational and teaching program in the fields of mental hygiene and psychiatry. The diagnostic center was located close to the medical school of the University of Wisconsin with a specific, two-fold purpose in mind. First, the center could make maximum use of the university affiliation. All staff appointments are made from the faculty of the medical school by approval of the dean of this school. This means that medical appointees must carry faculty rank. The administration of the diagnostic center and its operations is the responsibility of the State Department of Public Welfare. The entire program is one in which the psychiatric institute of the university and the Division of Mental Hygiene of the Department of Public Welfare are linked together under joint directorship. The other intention of the link with the medical school was to obviate the necessity of duplicating some medical services.

The new diagnostic center building not only houses the 76-bed, inpatient, clinical facility but also provides space for the administrative offices of the Division of Mental Hygiene. This is in accord with the excellent philosophy of this state that the administrative personnel in the Division of Mental Hygiene should continue active participation in clinical practice, and the hospital provides the physical setting where this philosophy can be carried out in actual practice. In this project, great credit should be given to Dr. Leslie Osborn, who came to Wisconsin about four years ago. Since that time, he has set up the basic background for a well-conceived and well-coordinated mental hygiene program which has been receiving wonderful support from the citizens, legislature, governor, and private and public organizations concerned. This state, with 3,500,000 people, has already invested $38,500,000 in construction of mental hygiene facilities and is committing itself further. As the state constitution does not allow borrowing, this is all being done with private income, in this case a good indication of the genuineness of the support that this project is receiving. Wisconsin has a joint state-county system for caring for the mentally ill; and Governor Kohler has estimated that if the contribution of the counties for construction of psychiatric facilities is added, a total of nearly $40,000,000 has been invested.

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* Read at dedication of Wisconsin Diagnostic Center, Madison, September 10, 1954.

** Clinical Professor of Psychiatry, University of Colorado Medical School.

Of the 71 counties in the state, 36 have individual mental hospitals which vary in size from about 150 to 350 beds. It appears that, to a large extent, these hospitals have served the purpose of providing care for the relatively amenable patients from the state hospitals, of which there are only three. These individual mental hospitals serve an excellent function in so far as they allow the treatment and care of mental patients in small units near the home community. Wisconsin has two relatively large state mental hospitals, one in Madison and one near Oshkosh, with capacities for 900 and 1,100 patients respectively. In addition, there is a 350-bed hospital about 60 miles from Madison for the criminally insane and for the more difficult custodial cases. There are two large, well-run institutions for the mentally defective designated as the northern and southern Wisconsin colony and training schools. These have capacities of about 1,800 and 1,300 respectively. There is a total of between 8,000 and 9,000 persons in county mental hospitals. This does not include those in the hospital for mental diseases in Milwaukee County; this is one of the county institutions, but is as big as either of the state hospitals.

These figures may give you some idea of the size and magnitude of the problem being tackled so efficiently and so progressively by the State of Wisconsin. Your program in this state is obviously one which is looking forward to the future and holds a bright promise in the struggle against mental illness and disorder. So often, unfortunately, state programs become stagnant, and progressive and preventive psychiatry are reduced to the level of custodial care and nothing else. Nothing, of course, is more shattering to the morale of the psychiatric community when such is the case.

It is because of the bright features seen in the state of Wisconsin that I have chosen as the theme of my dedication address the concept of "New Horizons in Psychiatry." My main theme is the necessity for maintaining and increasing the drive to handle, to contain, to alleviate, and eventually to conquer the scourge of mental disorder. I want to review what is being done in various fields of preventive psychiatry to achieve this goal. It is my conviction that preventive psychiatry has one of the most important contributions to make to human life and its vicissitudes and that, used with the discipline of science and the humility of the medical philosophy from which it sprang, it can advance the sum of human happiness and raise immeasurably the status of man.

Preventive Psychiatry and Educational Training

There is still considerable controversy regarding the purposes and technics of psychiatric education. It is agreed that motivation and interest on the part of students of psychiatry are of primary concern. The well-motivated and sincerely interested student will ultimately transform his interest and knowledge into useful activity, activity in all phases of medical practice. A diagnostic center such as this is a strong foundation of well-trained personnel with adequate facilities for the study and treatment of all types of mental disorder. It provides the proper educational background for the intelligent student. Except in the fields of public health, pediatrics, and rehabilitation, very little effort is made in the average graduate training program to inculcate an interest in positive health management, for the prevention of disease. It is regrettable that psychiatry has not progressed further in the field of prevention. It is to be hoped, therefore, that this new diagnostic center will set an example to other, perhaps older, centers in regard to this important problem of prevention and its integration in graduate and undergraduate training programs.

A training program is not limited, however, to the problems of diagnosis, treatment, and prevention. It is sometimes said that the specialist knows more and more about less and less. This is not so and is certainly untrue of the psychiatrist. There is scarcely a field of medicine which does not have psychiatric implications. Public health, industry, education, pediatrics, internal medicine, and surgery have all attracted psychiatric attention. The psychiatrist is no longer confined to the limits of a mental hospital. He must take cognizance of the whole patient, rather than limiting his interests to so-called psychological symptoms. It is gratifying to know that this center will also be staffed by members from other disciplines in the field of medicine. The psychiatrist and internist must work together in a surge of cooperation and inquiry in the field

of psychosomatic medicine. The use of the word psychosomatic is unfortunate. The term implies that some diseases lie within the domain of the internist alone or of the psychiatrist alone. Two thousand years ago Socrates showed that he was well informed regarding the mind and the body; he said that the part can never be well unless the whole be well. There is no cure for the body apart from the mind. All disease was to the Greeks psychosomatic. Despite the tremendous amount of research that has already been done in this so-called field of psychosomatic medicine, it is doubtful whether the psychiatrist can yet say that he can successfully treat more than a few of these disorders. There is a need for humility on the psychiatrist's part; and there is need for greater understanding and tolerance on the part of the internist, who sometimes expects too much of the psychiatrist in the field of psychotherapy.

The provision of 76 beds in this center will provide ample clinical material, not only for treatment but also for study and research. The very rapid growth of clinical knowledge of the psychiatric disorders during the last 20 years has been somewhat bewildering. A doctor who embarks on a psychiatric training program today is faced with a vast body of psychiatric literature, much of which is couched in language which tends to confuse rather than to clarify. This rapid growth has been very stimulating; but, unfortunately, it has been accompanied by neglect of the basic fundamentals of clinical psychiatry. In the board examinations in psychiatry, we meet candidates who have completed five years of training in a specialty and yet show an alarming ignorance of some of the more elementary clinical knowledge so essential for the growth of clinical practice in psychiatry. No amount of abstruse pedantic learning on the part of the psychiatrist will compensate for a failure to recognize the early signs of a delirium or to detect those symptoms which foreshadow suicide. This knowledge can only be learned at the bedside under the guidance of a person who has received sound training in clinical psychiatry. It is to be hoped that this center will set an example to other university departments in the standard of the inpatient care which is provided.

Preventive Psychiatry in Industry

Ours is the most highly industrialized civilization the world has known. Such a cultural structure brings us luxuries undreamed of years ago but also brings in its train its own special problems. The factory can provide conflict and anxiety as well as the highest rates of pay in the world. An efficient and practical program of mental health has been in operation for some years now, but there is a continued need for study and research in the special problems of industry. The psychologist has been introduced, with the technics of time and motion study, personnel placement, and other special procedures. For a time, the parts of man were studied; the man as a totality was forgotten. Now there is an increasing realization of the total nature of man and his industrial environment, and clinical psychology has taken over from the piecemeal approach of psychometry.

Industrial psychiatry has now taken its place by the side of industrial psychology. The prime function is to know the problems of maladjustment and emotional disturbance. The industrial psychologist has contributed enormously to the betterment of operational procedures and technics, but industrial psychiatry is making its own highly important contribution in the selection of employees, in the maintenance of mental health in these employees, and in the reduction of work factors liable to foster the stresses which are injurious and sometimes fatal to mental balance. It is too easy nowadays to talk simply of "no more square pegs in round holes" as though industrial psychiatry embraced only the principles of vocational guidance and selection. Did you ever notice that in carpentry the square peg will fit much more tightly in a round hole than will a round peg in a round hole? A human square peg in a round hole, under the hammer of circumstance, may be a tighter and more stable fit than any other. I am, of course, simply noting the inefficiency of rigid principles. The psychiatrist in industry has a thousand and one functions to perform; they range from industrial counseling to maintaining good employer-employee relationships. It is essential to the maintenance of our position of world leadership that we continue to tackle the problems of our industrial way of life.

Preventive Psychiatry and Society

Neither society nor man is an isolated phenomenon; man cannot live without society nor can society exist except as a human phenomenon. It has been said by the cynic that man is a gregarious animal that hates his fellow man. He hates because he has never learned to live with himself. The concepts of preventive psychiatry are more and more being applied not only to man as a unit but also to man as a social assemblage. Society is an awkward concept, in so far as we all realize its importance but are so hard put to define it. Man has found that he cannot live alone, and he has found to his dismay that he is unhappy living in groups. What is he to do? He may turn in upon himself and be profoundly distressed by what he finds there, or he may become more flexible in his social living and keep society a healthy organism rather than allow it to become sick and old. That powerful social commentator, Aldous Huxley, who is possibly the most erudite of all our social commentators, has compressed into a few lines some of the bitterness and futility, some of the hope and promise of society, in the following lines:

"Cruelty and compassion come with the chromosomes
All men are merciful, and all men are murderers.
Doting on dogs, they build their Dachaus;
Fire whole cities and fondle the orphans;
Are loud against lynching, but all for Oakridge;
Full of future philanthropy, but today the NKVD
Whom shall we persecute, for whom feel pity?
It is all a matter of the moment's mores,
Of words on wood pulp, of radios roaring,
Of Communist kindergartens or first Communions.
Only in the knowledge of his own Essence
Has any man ceased to be many monkeys."

The aim of preventive psychiatry in every field of human activity should be the inculcation within man of insight into the nature of his essence, for without that insight man is but "many monkeys." Preventive psychiatry in the social sphere is, at the moment, pulling out of the phase of major readjustment necessary in the transition from the state of war to the state of uneasy peace, not only in the economy, but in the attitudes and ways of thinking. Large-scale public education programs based on the principles of psychodynamics and cultural psychology are being instituted. We are too close to this period to discern clearly whether or not preventive psychiatry has helped in the avoidance of social confusion and disintegration; but I personally am optimistic that not only has a degree of adjustment been achieved, but that, in the future, the experience gained in war and in the adjustment period following war will serve to further progress toward emotional stability in what Arthur Koestler has described as "The Age of Longing." It is perhaps appropriate here to acknowledge the debt psychiatry owes to the special branch of psychoanalysis, as far as preventive psychiatry in the social sphere is concerned. What seems to be required is an integration of the specific technics and procedures of psychoanalysis with the perhaps more comprehensive principles of biosocial psychiatry to form a broad base upon which can be erected the foundations of the dynamic, flexible psychiatry we envisage for the future. One of the most penetrating accounts of society from the approach of preventive psychiatry is James Halliday's *Psycho-social Medicine —a Study of the Sick Society.* His final chapter summarizes very appropriately how I feel concerning the social function of the psychiatrist:

> "As social sickness is a disease, the basic observations upon it are appropriately made in terms of medicine and arranged under the familiar categories of symptoms, diagnosis, pathology, etiology, epidemiology, treatment, and prevention. In this way the knowledge gained attains a form communicable to and understandable by others, but much further field investigation is to be done before social therapeutics becomes a subject of medicine in its own right. The aim of this work is essentially practical, that is, it is a contribution to social synthesis and thereby also to psychosynthesis, for the one is the reflection of the other. But without a 'mental fight'—intellectual, emotional, and spiritual—these matters cannot be grasped, and the sword that might have been used will remain 'sleeping in the hand.' "

Halliday's concept of psychosocial medicine is one which should be investigated closely and, if found valid, extended to the limit. One further quotation from his work may again be very appropriate here:

> "The new medicine (that is, psychosocial medicine) provides us not only with a new perspective but gives us a

better sense of proportion. For example, what shall it profit a community if it adds three inches to the average stature of its members, and regards this as social progress, when in reality the community is in a state of regress. In other words it is neither sense nor science to concentrate our thoughts and endeavors on the physical aspects of nature to the neglect of its spiritual or psychological aspects, when it is but in the comprehension of these alone that man can consciously save himself from further social catastrophe and even destruction. First things should surely come first."

Preventive Psychiatry and Research

If we look at the needs and opportunities in the field of psychiatric research, we are almost overwhelmed. Rather than feel helpless before the work to be done, however, we should press on with this research in accordance with three broad principles. The 1952 conference in Oxford, England, on "Prospects in Psychiatric Research" put forward these three broad principles to which I give complete affirmation. As far as I am concerned, *the first and most urgent goal* is the concentration of all available research competence and knowledge upon the major psychoses. The appalling statistics of hospitalization for the major psychotic conditions should cause such a concentration of public feeling and create such a welter of progressive legislation that the problem could possibly be markedly ameliorated in the lifetime of most of us attending this meeting. Geoffrey Vickers, in summing up this aspect of the conference, said:

> "General paralysis of the insane, which filled the mental hospitals forty years ago, has become a rarity. Its specific cause and its specific cure are known. We cannot be sure that any of the others will prove susceptible to equally specific treatment, but no one can assume the contrary. The mental patient lies in the hospital, now a burden to society and a challenge to science; and he should, I suggest, remain the focus of attention of those whose primary concern is mental health. His needs are clamant, his symptoms are gross, his treatment provides what is likely to remain a wide and fruitful field for experiment on human beings. The study of specific mental disease and the study of general brain function cannot fail to enrich each other, and the mental patient would seem to be a focus for both."

The second goal suggested at the conference was to find more reliable ways of raising the "threshold of the bearable." We know how it is possible within a relatively few generations to breed strains of rats so different in their resistance to stress that they constitute almost a biological anomaly. We can produce one breed of rat which will show a resistance to stress far above the average and another breed with a resistance far below average. Unfortunately, little is known about the difference between the breeds. If only we could produce a breed of human beings with a resistance to stress far above the average, what a blessing it would be, unless, of course, such a breed elected to elevate its stresses along with its tolerance level! Vickers has this to say upon the subject:

> "If there is one quality more precious than any other in a world like this, it is the capacity to carry mental stress; and nothing would make a greater contribution to mental health than a better understanding of this quality, how to recognize it, to develop it, and to reinforce it."

The third goal in psychiatry should be to reduce the tension value of environmental stimuli, to reduce the "unbearableness" of the stimuli. Let me give one more quotation from this Oxford conference, as it seems to sum up very nicely the nature of this third goal:

> "This is, of course, no virgin field; since conscious thought dawned, religion and philosophy have been no less concerned than psychology is today with the problem of making experience bearable. No aspect of neurosis is more baffling than its subjective quality, and it may be that the future of mental health depends more on the habits of mind which society induces than on all the resources of doctors and surgeons. The difference between the normal and the maladjusted lies not so much in the nature of the impulse life itself as in the individual's way of handling it."

With these three goals in mind as frames of reference, there can be a greater integration of psychiatric research to the extent that perhaps some day mental illness can be regarded as no more of a complication than some now relatively rare complication in physical medicine.

Preventive Psychiatry and Geriatrics

The expectation of life in this country is increasing with each decade; and while this may give me the pleasure of the prospect of 20 years more golf, it also brings very much to my mind the problems of geriatrics and how severe these problems may become for those who practice preventive psychiatry. In certain cultures scattered throughout the world, the old are revered and looked upon as a great asset to the family structure. Unfortunately, in our own culture pattern the old are looked upon, quite illogically and unwisely, as a liability. We are becoming more and more aware in psychiatry that longevity is bringing with it a special crop of psychiatric problems which require careful and patient analysis and handling.

We must face the fact that, because of the great strides forward that we have made in medicine, our people are living longer. This means that every decade we are increasing the number of what we call "old people" in this country. Occasionally, we are given rather frightening figures which show that by about 1990 there will be more people over 50 than under 50.

A community usually seems to be immensely proud of the centenarian in its midst, not quite so proud of the nonagenarian, less so of its octogenarian, and positively cavalier in its treatment of its septuagenarians. Each centenarian, of course, has his own recipe for reaching this nice round figure. Each such recipe flatly contradicts the recipe of the centenarian in the neighboring community. Some seem to have achieved their age by living by the precepts of the Bible, others by the precepts of the Devil. A story is told of a preacher exhorting his congregation to cast out hatred from their hearts and souls and to look upon their neighbors only with love and kindness. He said, "Stand, all those who have enemies, who have people that they hate"; and the whole congregation rose except the centenarian sitting smugly at the rear. The preacher told his flock that they should take a lesson from the old man and said to the old man, "Can you tell us briefly how it is that you have no enemies, how it is that you hate no one?" The centenarian cackled as only a centenarian can and said, "I have outlived the whole rotten crew." Forgive any seeming flippancy on my part, for in my estimation the psychiatric problems of gerontology are more important than the medical problems. The old are increasingly being made aware of their isolated status in the community and, to some extent, are gaining the impression that they are a drag and a liability. In this sphere in particular, the psychiatrist who is oriented toward preventive medicine can be of inestimable help in directing the process of adjustment, both of the old to the community and of the community to the old.

In any case, when is a man old and simply not at the top of the scale of being middle-aged? Is the term "old" an absolute to be applied to everyone at say the age of 65 or 69 or 71; or is it, as I consider it to be, a meaningless term and one which carries so much emotional connotation that it should be discarded? It seems so ridiculous that there should be set retirement ages, that there should be established ages beyond which it is almost impossible for a man to seek employment. It is one of the many confusing paradoxes of our times that medical science should prolong the life of men and in so doing leave society with a plethora of physically capable, yet unemployable, depressives or "apathetics," if I may coin such a term. There is neither rhyme nor reason in prolonging the life of man to a certain stage unless at that stage he can be a functioning part of his society and can feel that he has some part to play. I would emphasize again that the function of preventive psychiatry is to give such an aim to the individual and to inculcate in the community an appreciation of the problems to be faced in the interaction of the "old" with society.

Preventive Psychiatry, Alcoholism and Crime

The growing incidence of alcoholism and the increasing rate of crime are two related problems. The treatment of the 4,000,000 alcoholics in the United States provides a challenge to the medical profession and to the community. The goal of psychotherapy is to resolve the emotional problems which underlie the patients' flights into alcoholism.

Should not the goal rather be one of prevention? This diagnostic center may perhaps foster further research into the underlying causes of alcoholism. Such research should not be regarded as and should not consist of a purely academic inquiry but should be oriented to practical situations. Findings should be stated in terms that suggest a practical answer to the problems of alcoholism.

The grave incidence of criminal behavior requires the searchlight of our attention. The relationship between society and the criminal cannot be understood merely in terms of the criminal, the judge, and the penitentiary. Those criminals whose behavior reflects a neurotic disorder should be considered for treatment. This privilege has for centuries been extended to the psychotic criminal.

The facilities of a university-staffed diagnostic clinic provide a background for further study into the psychology of criminality. It is clear that the recidivist is not changed by repeated imprisonment. The recent experiment at Herstednester in Copenhagen deserves our attention. At this unique social institution, which has some of the features of a hospital and some of the features of a prison, success has been obtained in the rehabilitation of chronic offenders. Such results lend a practical backing to the pleas made by penal reformers for a more tolerant and understanding approach to the dissocial person. Intensive investigation into the psychology of the criminal act supplemented by further research into the incidence and nature of abnormal electroencephalographic tracings, already noted in a proportion of offenders, should be conducted.

Custodial Care

Although custodial care is thought or supposed to be something out of the past, the traditions of the custodial mental hospital still remain in many of our more advanced treatment centers. Old customs die hard, and nowhere is this more true than in the psychiatric hospital.

No longer is the psychiatrist regarded as the sole person concerned in the therapeutic treatment of the case of mental disorder. The nurse, the social worker, the occupational therapist, the psychologist, and the recreational therapist are all part of a therapeutic team. It is now recognized that the hospital itself constitutes a unique cultural segment within the community as a whole. The object should be to make this cultural background function as a therapeutic community so that patients will themselves form part of the treatment situation. Relatives are often concerned that association with other mental patients will have a harmful effect. It is now being increasingly realized that the reverse condition may operate, that patients as a group may constitute the very norm from which individually they differ.

No longer can the psychiatrist confine himself to treating the patient's illness; the doctor's work does not cease with the mere cure of his patient's condition but only when he has done his utmost to enable the patient to function again as an active member of the community. Rehabilitation is not something that can be left to a state employment agency, it is not something which the social worker can arrange in a few minutes by phoning half a dozen employers; rather, rehabilitation requires the same care, attention, and searching inquiry as the diagnosis of the original complaint. The demands made upon the psychiatrist are great. He must be a clinician first and foremost; he must be able to work in harmony with other members of the medical profession who have different specialties. But more than this, he must have a working knowledge of matters far beyond the consulting room. The word "health" has been defined in the constitution of the World Health Organization as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. This definition indicates the extent of the psychiatrist's responsibility in the care of his patients.

The complete physical, mental, and social well-being of the person has its roots in the early years of development. The psychiatrist has not always been wise in the advice that he has offered to parents, and there is a growing realization of the limitations as well as of the capabilities of psychiatry. With respect to a child's development, there is no time when the psychiatrist's advice is more important than during the very early years of the child's life. There is a need for a greater understanding and emphasis on normal personality development and func-

tion. Illness in adult life cannot be understood merely in terms of abnormal personality development; we must also have some knowledge of what constitutes normal development, not only through childhood and adolescence but right on throughout the life span. The variations in normal personality make our understanding more difficult but should serve as a stimulus in our attempt to detail favorable and unfavorable factors in development.

Well-equipped diagnostic centers such as this one will be able to add to their knowledge by improved methods of follow-up care. The patient will not become just a statistic on discharge from the hospital, but contact will be made with him from time to time in the ensuing years in order that early treatment may be instituted in the event of a relapse and in order that the hospital and psychiatry as a whole may benefit from the relationship which extends beyond the confines of the hospital. Such follow-up care may be integrated with improved community clinic services.

Because of these community clinics, people have become more willing to accept psychiatry and psychiatric treatment. Treatment in a psychiatric center is no longer regarded as something to be ashamed of. The psychiatrist cannot afford to isolate himself from the community, and the community cannot afford to neglect the services offered by the modern department of psychiatry. With the extension of community clinics, practical application can be made in the extension of public health preventive programs. At present, prevention continues to be an academic problem rather than an active practical reality. Community clinics form the first line of attack in the development of sound mental hygiene within the community.

This diagnostic center should help to cultivate a sense of social responsibility within the staff. A sense of social responsibility would demand that the psychiatrist provide treatment not only during the acute stage of illness but also on the patient's return to his work. In the future, this interest in the patient will perhaps extend to the whole family and from the family will radiate out to form a positive program emphasizing the total care of the sick patient.

Summary and Conclusions

I have attempted to cover some of the main features which I think constitute the current horizons of psychiatry. Broadly speaking, these deal with the development of skills in diagnosis and therapy; an increase in educational and training programs; and an increase in attention paid to the pathology of society—the "sick society," as Halliday calls it. In psychiatry we must move closer in the direction of over-all integration. The party lines and dogmatism of the "schools" must all in some way be integrated and fused in the broad principles of biosocial psychiatry. Psychiatry is passing out of the turbulence of its childhood and adolescent phases and must accept its adult, mature responsibilities. It has sown its wild oats; now it must settle down to increasing productivity. Your Wisconsin Diagnostic Center makes this possible.

1801 High Street.

MEETING OF WISCONSIN CHAPTER OF INTERNATIONAL COLLEGE OF SURGEONS

The spring meeting of the Wisconsin Chapter of the International College of Surgeons will be held from 12:00 to 2:00 p.m. on Tuesday, May 3, at the Crystal Ballroom, Hotel Schroeder.

Following is the program scheduled for the meeting:

1. Introduction of Dignitaries and Members
2. Scientific Program (Moderator, Arnold S. Jackson, M. D., Madison)
   a. "Ankle Fractures"—J. M. Regan, M. D., Milwaukee
   b. "Management of Toxic Surgical Thyroid"—Karl Schlaepfer, M. D., Milwaukee
   c. "Preparation of Patient, Managemental Problems in Intestinal Surgery"—Martin Malensek, M. D., Milwaukee
   d. "Congenital Absence of the Vagina and Its Surgical Correction"—E. A. Habeck, M. D., Milwaukee

   Each of the topics will be a 15-minute presentation, followed by a 5-minute discussion period.
3. Business Meeting (Members only)

For reservations, write Dr. John T. Sprague, 109 East Johnson Street, Madison, Wisconsin.

Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

Editor—DOROTHY W. BETLACH, M. D., Janesville, Wisconsin

Convulsions During Anesthesia*

Convulsions during anesthesia occur in 1 to 2 cases per 10,000.[1, 2] Approximately 20 per cent of these cases result in death from anoxia,[3, 4, 5] and a significant number of patients recovering from convulsions have permanent cerebral damage. The actual incidence of seizures is relatively uncommon, but the severity of some of the results should make everyone aware of the problem, its probable causes, prevention, and treatment.

The first convulsion during anesthesia was reported in 1927.[6] The agent used was ether, and the term "ether convulsions" was in vogue for many years thereafter. Recently this misnomer has been discarded because convulsions have been observed during the administration of virtually all anesthetic agents, including drugs administered regionally and intravenously.

Convulsions may vary from mild, brief twitchings to markedly severe, generalized seizures and may occur at any time during the period of anesthetization. Children and young adults are more susceptible than other patients.

Common causes of convulsions during anesthesia are: carbon dioxide retention; oxygen lack; hyperthermia which may be due to fever, dehydration, overheating of the operating room, or overdraping the patient; deep anesthesia with respiratory depression; overdosage of regional anesthetic drug; and air embolism. Other predisposing factors include: excessive premedication, especially with atropine; infections; electrolytic imbalance such as calcium deficiency, acidosis, or alkalosis; and surgical stimuli. It also has been suggested that there is an interference with the respiration of the brain cells during anesthesia and the cerebral hypoxia causes the convulsions.[7]

Management during the anesthetic period is important. An obstructed airway, inadequate carbon dioxide absorption, heat retention, inadequate ventilation, and diminished oxygen supply produce hypoxia. Such alteration of physiology is conducive to convulsions.

Case No. 62—A nine-month-old, white girl weighing 16 pounds was admitted to the hospital for repair of a second-degree cleft palate. Physical examination showed a healthy child except for the congenital defect, and laboratory studies of the blood and urine were negative. The temperature was normal, and the child appeared well the day before the operation.

One hour preoperatively, 0.17 mg. scopolamine was given. Induction of anesthesia was with Vinethene, followed by ethyl ether, using an open mask technic. Approximately seven minutes later, orotracheal intubation was performed easily and quickly with no evidence of hypoxia or apnea. Insufflation of nitrous oxide and oxygen (about 2 liters each) with the addition of ether was started, using Ayre's non-rebreathing technic. Thirty seconds later the child had brief cloniclike movements of both arms and both legs and rapid development of a generalized clonic convulsion. Respiratory exchange was inadequate, and artificial ventilation by periodic occlusion of the expiratory port of the Ayre's tube was started immediately. Four hundred milligrams of 10 per cent Pentothal was administered rectally, and the convulsions stopped approximately five minutes later. Artificial ventilation was continued until spontaneous respirations became adequate 10 minutes later. The rectal temperature taken at this time was normal. The endotracheal tube was removed, and the child was kept under observation in the operating room for 15 minutes. The operation was postponed; and the patient was returned to her room, where she was awake and apparently normal two hours later.

* Guest Contributor, George C. Kreuter, M. D., Milwaukee.

After four months, the child returned to the hospital; at this time the palate was repaired during general anesthesia without incident. The same technics were employed with the exception of the premedication; 350 mg. 10 per cent Pentothal was given rectally 20 minutes preoperatively.

The cause of the convulsion is not clear. The seizure was so severe that all individuals associated with the case were gravely concerned about the outcome. The rapid recovery and the uneventful second anesthetization indicate that the underlying cause was a temporary, easily reversible derangement of the child's physiology rather than a convulsive diathesis.

Prevention of convulsions should be one of the goals of every anesthetist. Good preoperative preparation and close attention to every detail of the anesthesia are the best prophylaxis. Twitchings of the facial muscles or the small muscles of the hands are a warning of impending danger. The anesthetic procedure must be reviewed immediately, with every effort being made to determine causes of the twitchings, and adjustments made accordingly. Ineffective carbon dioxide absorption in a closed system should be corrected or the technic should be changed to a semiclosed or open system. Oxygen available to the patient should be increased and depressed or shallow respiratory excursions assisted manually so that oxygen in higher concentration is present at the alveoli. Intravenous fluids should be used to correct any fluid depletion. If the body temperature is elevated, ice packs or other cooling methods must be applied to the patient to prevent damage from hyperthermia.

If convulsions do occur, the following principles of treatment must be instituted: (1) the patient's respiration must be maintained; (2) the convulsion must be stopped; (3) circulation, which soon fails, must be supported.[8] Artificial ventilation should be started immediately since the majority of patients are unable to breathe of their own volition. Compression of the chest is not adequate to aerate the lungs. Manual compression of a breathing bag using 100 per cent oxygen and a face mask should be performed. If artificial ventilation does not correct the situation or is unsuccessful in inflating the lungs, additional procedures are necessary. One to two cubic centimeters of 2½ per cent Pentothal given intravenously is usually effective in stopping the convulsion. Muscle relaxants such as d-tubocurarine and succinylcholine also have been used, but these drugs may increase the hypoxia by the additive effect of respiratory muscle paralysis. Large doses of any of the drugs are not necessary and will only contribute to the circulatory depression and prolong the apnea. An oropharyngeal airway or endotracheal tube should be inserted as soon as possible if prolonged artificial ventilation is necessary. In children, an endotracheal tube, with a direct connection between the tube and breathing bag is preferred since gaseous distention of the stomach and small bowel may result from the use of a bag and face mask for even short periods of manual respiration. General supportive therapy such as intravenous fluids should be given to the patient until he is able to care for himself adequately. The operation should be postponed or terminated as quickly as possible.

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AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY EXAMINATION

The next scheduled examinations (Part II), oral and clinical, for all candidates will be conducted at the Edgewater Beach Hotel, Chicago, from May 11 through May 20. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates. Candidates who participated in the Part I examinations will be notified of their eligibility for the Part II examinations as soon as possible.

Let a Health Film Help You Give That Talk

As It Looks to Your State Board of Health

VISUAL aids have long been recognized by both lay and professional groups as one of the most effective means of presenting a health message. The old saw, "one picture is worth a thousand words," has more truth to it than is at first apparent. That's why the State Board of Health has developed one of the largest and most active health film libraries in the entire nation.

Schools, colleges, hospitals, P.T.A.'s, medical societies, and church groups have learned the values to be gained from presenting the story of health on films. With each passing year, requests for such aids from our film library have continued to increase. Our records tell us that our films are shown to nearly a million Wisconsin residents during each calendar year.

Medical and public health films have grown up. They have improved in quality until now they are too good to miss. Modern health films are dramatic and colorful and actually help people to improve their health habits. Many are produced by such well-known companies as R.K.O., Coronet Films, and Encyclopedia Britannica; are directed by men of "production know-how" such as Walt Disney and Eddie Alberts; and feature some of the top names of screen and television.

Steadily expanding to meet the demand and to keep pace with developments in the field of health visual aids, the State Board of Health film library now has prints of nearly 500 films from which to choose a program aid. Running the gamut of health subjects from appendicitis to yellow fever, films are available without charge to help you present your message.

Perhaps your needs are for a film on home safety. There's an excellent new one entitled "You Can Take It With You" that's bound to make your audience think. It effectively links industrial plant and home safety activities by showing how a person can avoid accidents involving housekeeping, ladders, electricity, and home repairs by using industrial safety practices. Or perhaps the local service club requests a talk on cancer. There's an amusing, and yet educational, film entitled "Man Alive" available for your use. Through the media of cartoons, the importance of regular physical examinations in the discovery of early cancer is depicted.

And when the local P.T.A. wants a doctor's comments on the emotional and physical health problems of teen-agers, why not let a film like "Age of Turmoil" tell much of the story for you? It graphically discusses the usual characteristics of adolescents and their needs and the different ways in which they make adjustments to their problems.

Called upon, as you frequently are, for public appearances and talks to various community groups, you are passing up a "good bet" if you fail to consider the possibilities of using one of these health visual aids. Films save time, which you do not have to spare, and will also help you to make a more effective presentation.

Whether your needs are for a film for a professional group or for a lay audience, why not investigate the help available through your State Board of Health film library, State Office Building, Madison 2, Wisconsin. Lists and descriptions of all our visual aids are available on request. A postal card will reserve a film for you months in advance, and you will automatically receive the film a few days before your meeting. Health films are "at your service"—why not let them work for you?—PHILIP DYKSTRA, *Director, Division of Health Education.*

YOU'LL WANT TO SEE THIS NEW FILM

"Lung Cancer—The Problem of Early Diagnosis" illustrates complete x-ray diagnostic procedure, the value of exfoliative cytology and of bronchoscopy, and an exploratory thoracotomy. The need for periodic chest films as well as prompt action by the doctor is emphasized. (30 minutes)

This sound, color movie and those listed below were produced by the National Cancer Institute and the American Cancer Society especially for use by such professional groups as county medical societies, hospital staffs, and medical students. They may be borrowed from the State Board of Health Film Library, 1 West Wilson Street, Madison, or from the American Cancer Society, 652 East Gorham Street, Madison.

"Cancer—The Problem of Early Diagnosis" (30 minutes)
"Breast Cancer—The Problem of Early Diagnosis" (34 minutes)
"Gastrointestinal Cancer—The Problem of Early Diagnosis" (33 minutes)
"Oral Cancer—The Problem of Early Diagnosis" (33 minutes)
"Uterine Cancer—The Problem of Early Diagnosis" (21 minutes)

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- prompt control of infection
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Clinicopathologic Conference

Sponsored by the Section on Pathology, State of Wisconsin Medical Society
Guest Editor: Charles Altshuler, M. D.

REPORT OF A CASE*

A 69-year-old, white male entered the hospital with the chief complaints of shortness of breath, ankle edema, and nausea.

Present Illness: The patient had noted the above complaints during the three weeks prior to admission. He felt "full" after meals and often became nauseated. He admitted some weight loss but did not know how much. He had noted abdominal enlargement three days before hospital entry.

Past Medical History: This man had been diabetic for some years and at the time of admission was on 43 units of NPH and 15 units of regular insulin daily. He had had a gastric resection for a duodenal ulcer seven years before and had had an appendectomy and removal of a small cyst from the testicle at the age of 30.

Social History: The patient denied the use of alcohol or tobacco.

Family History: The family history was noncontributory.

Systemic Review: The systemic review revealed a chronic cough productive of a white sputum. The patient denied chest pain.

Physical Examination: The blood pressure was 114/64; and the pulse was irregular (believed to be auricular fibrillation), with a rate of 140 to 170. Respirations were 20; the temperature was 98.6 F. The patient appeared chronically ill and somewhat icteric. Moderate pigmentation was noted over the trunk and extremities. The sclerae were icteric. The heart was slightly enlarged. The abdomen was distended, and a fluid wave was detected; the liver was 4.0 cm. below the right costal margin in the midclavicular line. The testicles were atrophic, and a two-plus pitting edema of the lower extremities was observed.

Laboratory Findings on Admission: Urinalysis: Routine analysis revealed no abnormality; urine urobilinogen 1.97 mg./100 ml.

Blood: hemoglobin 10.5 Gm.; red blood cells 4,250,000 per cu. mm.; white blood cells 10,000 per cu. mm., with a normal differential.

Blood Chemistry: glucose 358 mg./100 ml.; nonprotein nitrogen 32 mg./100 ml.; urea nitrogen 23 mg./100 ml.; sodium 140 mEq./1.; potassium 4.2 mEq./1.; chlorides 103 mEq./1.; icterus index 14; total bilirubin 2.5 mg.; indirect .8 mg. and direct bilirubin 1.7 mg.; thymol turbidity 1.75 U.; alkaline phosphatase 6.7 B. U.; protein 6.78 Gm./100 ml.; albumin 3.33 Gm./100 ml.; globulin 3.45 Gm./100 ml.; bromsulfalein retention 38 per cent.

X-rays: On x-ray examination of the chest, moderate cardiac enlargement with hypertrophy of the left ventricle was observed. Marked calcification of the ascending aorta was also seen.

Electrocardiogram: This showed auricular fibrillation with a ventricular rate of 120.

Hospital Course: While in the hospital, the patient was treated with digitalis, diuretics, intravenous fluids, and sedatives. His blood sugar usually varied from 83 to 474 mg. per 100 ml., and he was given 30 to 60 units of regular insulin per day. On the third hospital day, he was found to be in coma. His respirations were shallow, and the blood glucose was 26 mg. per 100 ml. His response to glucose therapy was slow, and he remained lethargic and confused for several days. His mental condition temporarily improved, but he continued to appear dehydrated. Ascites increased and, gradually, confusion recurred. Terminally, the patient passed bright red blood from the rectum. He died 15 days after admission to the hospital.

* * *

Dr. Samuel Rosenthal (Internist): As I have said on previous occasions, I think that the chief purpose of these clinicopathological conferences is to see if one can logically make the diagnosis from the facts stated. I would rather be wrong while being logical than be right in making the diagnosis on some obscure fact that doesn't fit the rest of the clinical picture.

I think the first thing to do in making a diagnosis is to outline the salient positive features in the case. And what were those features here?

* From St. Joseph's Hospital, Milwaukee.

We had a 69-year-old man whose chief complaints were a feeling of fullness after eating, a feeling of weakness, and questionable weight loss.

The history presented nothing of significance to direct our attention to some tissue system. Of course, the feeling of fullness is related to the gastrointestinal system. The weakness and the weight loss may be related to any system.

What were the positive findings on physical examination?

First, this man had an enlarged liver, which is very significant. Second, he had ascites; and third, he had ankle edema. Fourth, he had a rapid heart rate which was irregular. Fifth, he had icterus; and sixth, he was said to have been pigmented. These were the crucial findings.

Next, we must consider the objective laboratory findings. We will emphasize here the findings that were positive, not the normal findings. The patient had a normal red blood cell count and white blood cell count, for example, so we need not dwell particularly on them. The pertinent findings which impress me are:

1. He had 38 per cent dye retention in the Bromsulfalein test, which is definitely abnormal.
2. He had 1.9 mg. of urobilinogen excreted in the urine; this may be a little above the average normal of 1.5. Some, however, take the excretion of 2.0 or 4.0 mg. as being within normal limits.
3. He had an enlarged heart. We can call that a laboratory finding although the x-ray man may feel a little disturbed about calling the x-ray a laboratory procedure.
4. He had changes in the plasma protein picture. His total protein was normal. You will notice, however, that while the total protein was 6.78 Gm. per 100 ml., the globulin was 3.45 and the albumin 3.33; this is the reverse of the normal quantitative relationship.
5. He had a slightly elevated icterus index of 14; the normal, of course, is 6 to 8. Thus, he had evidence of an accumulation of bilirubin in the blood. This is verified by the fact that the total bilirubin was 2.5 (the normal is generally given as up to 1.0 mg. per cent). The direct acting bilirubin was 1.7 mg., and the indirect was 0.8 mg. per cent. The normal of the direct bilirubin is 0.1 to 0.2.
6. He presented this picture of liver damage, then, plus manifesting objective signs of diabetes; *viz.*, an elevated blood sugar and the necessity of taking insulin. That brings up another important feature.

The man was 69 years old and was on 43 units of NPH and 15 units of regular insulin. I think that is significant. You know that patients under the age of 50 or 55 may require that much insulin, but it is unusual for older patients to need so much unless some complication or abnormality makes the diabetes unstable and the patient insulin-resistant and hard to control.

You will recall that he had calcification of the aorta, but that is of questionable significance. Since he was 69 years of age, he could well be entitled to that.

Thus, in essence, he had a triad of important signs and symptoms:

1. An enlarged liver with functional impairment
2. Diabetes difficult to control
3. Pigmentation of the skin

What disease, then, should these bring to mind? An enlarged liver, diabetes, and pigmentation should immediately make us think that this man had hemochromatosis. I know of no other single disease that will present these symptoms. One might ask, "What about Addison's disease?" No, I do not think so because Addison's disease is not accompanied by an enlarged liver, and diabetes is not a feature of it. The pigmentation, of course, could be Addisonian. What else is in favor of this being hemochromatosis? The fact that the patient is a man; hemochromatosis is probably 30 times more prevalent in men than in women. Another factor is the patient's age. This disease is usually seen in men in their 50's and 60's. Then, too, there is the factor that patients who have diabetes as the result of hemochromatosis are notoriously difficult to control; this man had an unstable blood sugar. He had an episode of hypoglycemia where his blood sugar went down to 26 mg. Thereafter he rallied but then seemed to deteriorate again. Perhaps he had irreparable

damage to his brain from profound hypoglycemia. Of course, he probably already had some cerebral arteriosclerosis.

A word about this disease, hemochromatosis. It is a very interesting and a rare disease. Hemochromatosis may be defined as an excessive deposit of hemosiderin in the various organs of the body. What causes it? The present thought is that it is an hereditary, inborn error of metabolism in which ingested iron is absorbed abnormally by the intestinal mucous membrane. Normally, an individual ingests between 5 and 18 mg. of iron a day. The daily requirement for maintenance of blood building and other functions is about 12 mg. The interesting feature of iron metabolism is that while the body takes in iron through the intestinal mucous membrane, it excretes very little. In other words, it is like a ball valve mechanism. Once the iron is taken in through the intestine and deposited in various organs and in the bone marrow, relatively little of it—less than 1 mg.—is ever excreted in an active way. Therefore, if an individual absorbs a small surplus each day, say 20 mg. instead of the usual 12 to 15 mg., iron accumulates in the body. This excessive iron deposit occurs first in the liver. The pigments, hemosiderin and hemofuscin, give the organs their characteristic brown color. It is an interesting feature that the intestinal mucous membrane normally seems to know how much iron to absorb every day. If there is a lot of iron in the body stores, very little iron is absorbed, even though the patient ingests a great deal. If there is a depletion from hemorrhage, menstruation, or another cause, absorption of iron increases. In hemochromatosis, however, there is an inborn hereditary defect. The mucosal door is open, and iron is absorbed in "excessive" amounts every day. Actually, it is a small amount per day, but it lasts throughout the lifetime of the patient.

Incidentally, it is interesting that in a recent study[1] a group of French workers found that the children of people with hemochromatosis (they studied about 13 families) had an increased serum iron. The normal is 120 micrograms, and their blood iron was in excess of that. What does this mean? Apparently they were absorbing more iron from their intestines than they should. Furthermore, these children had a decrease in the unsaturated iron-binding protein. Let us say that we add 70 per cent more iron to the serum than was contained originally. Normally, that iron would still combine firmly with a serum protein. In these children, the serum is more nearly saturated; that is, you can't add much more iron that will be bound to protein.

What happens to the increased iron in hemochromatosis? It is put into the body depots. It is deposited first in the liver. When the liver can't take any more, the iron goes to the pancreas, the spleen, the skin, the testicles, the heart muscle, and the parathyroid glands. It has a predilection for glands of internal secretion and so goes to the adrenals. Hence, there is an excessive deposit of iron in most of the important organs of the body. In the liver, it produces the picture of portal cirrhosis; in other words, it provokes a fibrous tissue increase. It is also deposited in the liver cells themselves, and thus retrogressive changes of the parenchymal cells are observed. This combination, plus lobular regeneration, results in the characteristic histologic picture of cirrhosis of the liver. What about the pancreas? Iron is deposited in the cells, both acinar and islet, and in the surrounding fibrous tissue. The parenchymal involvement here may result in diabetes. Why is the diabetes mild in the beginning of hemochromatosis? Because it takes 30, 40, or 50 years until enough iron is deposited in these organs to cause the degree of structural abnormality which will disturb function. Thus, these patients start with a mild diabetes; but as the fibrosis and parenchymal damage become extensive, the disease gets worse. Because of the liver disturbance, there is also abnormality in glycogen storage and in the method in which glycogen is released. So here we have a patient in whom, because of increased absorption of iron since early infancy or childhood, abnormalities developed, first in his liver, then in his pancreas, adrenals, testes, and skin. Because of the diabetes and the insidious liver failure, the patient loses weight and becomes weak. Disturbance in the conjugation of the estrogens, a liver function, may be partially responsible for testicular atrophy, which was observed in this case. Also, in true portal cirrhosis, one may see spider nevi, little angiomatous spiders usually involving the upper part of the body, especially the head and neck. They are due to the dilating effect of excessive unconjugated estrogens. These were not seen here, but they should be looked for in every case of portal cirrhosis.

What about this man's heart failure? It can also be attributed to hemochromatosis, at least in part. Iron is known to be deposited in the heart and not infrequently has resulted in progressive heart failure. This patient had heart failure, liver failure, and disturbance in pigmentation. What about the skin pigmentation? This may be due to several pigments. It may be caused by hemosiderin, and in some instances melanin may accumulate. In this case, the accumulation of bilirubin may also have contributed to it. The pigmentation produced by accumulation of melanin is similar to Addisonian pigmentation and may well be caused by disturbance in adrenal function.

Why did the patient die? He died as a result of liver failure and hypoglycemia, which may have affected his brain and his heart.

Why is it that men, rather than women, get this disease in most instances? Women usually lose about 25 mg. of iron with every menstrual period and so an unusual accumulation is prevented. If the disease does occur in women, it is rarely seen before the menopause. It occurs in men because they have little iron loss.

There are really three types of hemochromatosis. The type we have discussed is called idiopathic. We do not know what causes it so we use that very glamorous word. Hemochromatosis of similar pathologic character may be seen in people who have had multiple transfusions, again because the body cannot rid itself of excessive iron. The third type of hemochromatosis has been reported in individuals who had nutritional deficiencies; it has been seen most often in Africa. Gilman has reported such cases. In this country, of course, the large majority of cases are of the idiopathic type. While only about 400 examples have been reported in the literature, there certainly are many more cases, some of which may not be recognized as hemochromatosis. The patients pass as diabetics with unstable diabetes or as ordinary portal cirrhotic patients.

Why might not this man have had ordinary portal cirrhosis? He could have had, but there is no history of alcoholism, although this, of itself, is not conclusive. However, we rarely see elderly patients who die of cirrhosis. This condition usually develops before 50 in those who imbibe liquor. If it hasn't developed by that time, the chances are that it will not. So you gentlemen who are approaching 50 and who imbibe freely can get some reassurance on that score. That's one reason I don't think this was portal cirrhosis; remember that there is no history of dietary deficiency and that the age is against it.

Another feature about the disease is that these individuals may develop a hepatoma, a cancer of the liver. In about 7 per cent of the cases, individuals with hemochromatosis develop a primary cancer of the liver. Of course, we see that complication in portal cirrhosis, too, where it is said to occur in about 5 per cent of cases. This patient may have had a cancer of the liver, but he had sufficient cause to die without it.

This interesting disease has been an enigma to treat for many years and still is. The treatment is difficult because if the patient is given enough insulin to control the diabetes, he will go into hypoglycemia. If one tries to limit the diet, the patient's starved liver does poorly. Also, there is no good way to get the hemosiderin out of the body except by repeated phlebotomies. You will notice that this patient was not anemic. The treatment is to do a phlebotomy every week, taking off about 500 cc. of blood. This removes about 250 mg. of iron. Since the iron deposited in the liver and pancreas is available for formation of red blood cells, we have, we hope, removed some of the iron from the parenchyma. The result, however, will depend on how much damage there is before the phlebotomies are done. If there is fibrosis and extensive parenchymal damage, taking out the iron isn't going to help much to correct the functional impairment of the heart, pancreas, and liver.

What else can be done? The secret of the treatment of the diabetic aspect is not to give too much insulin, to keep the patient on an adequate diet, and to let him have hyperglycemia rather than hypoglycemia.

In summary, then, this patient was a man over the age of 50 who presented an enlarged liver, pigmentation, and diabetes. I believe he had hemochromatosis with the deposit of hemosiderin in his liver, adrenals, testes, and heart. I believe he died in heart failure and as the end result of his diabetes.

* * *

Dr. C. H. Altshuler (Pathologist): Doctor Rosenthal's excellent presentation demonstrates, I think, the value of these clinicopathologic conferences. His reasoning, as al-

ways, is very good. Are there any comments from the audience?

Doctor W. L. Coffey: I, too, think this has been an excellent presentation since many things discussed were borne out in the clinical picture. First of all, this man had apparently been a diabetic patient for many years but had never required insulin prior to the beginning of 1954. After he had his insulin reaction, all long-acting insulin was stopped and he got along on something like 20 to 30 units of insulin a day—and got along far better than he had before. Second, during his hospital stay, he had a tight, distended abdomen. It looked as though he might have had an intestinal obstruction, especially since he had had gastric surgery previously. Early, he had high-pitched gurgles, tinkling in type; but these finally quieted down. At the time of surgery seven years ago, he had had a firm, pigmented liver; but that fact seems to have been ignored. If my memory serves me correctly, hemosiderin was found in his urine when it was checked here.

One question that came to my mind was whether or not he really had true diabetes; might it have been a type of hepatic disturbance of glucose metabolism? In other words, was his metabolic abnormality a result of the liver failure rather than true diabetes mellitus?

Doctor Altshuler: The difficulty in ascribing the carbohydrate abnormality to liver failure lies in the fact that an ordinary liver dysfunction results in a low fasting blood sugar; in this case, the fasting blood sugar was 380 mg. per 100 ml.

Dr. J. K. Karr: I would like to bring out one important fact and that is that not all patients with hemochromatosis actually develop diabetes. About four years ago we had a patient here whose earliest manifestations were those of heart failure, and we treated him for it. He had a severe gastrointestinal hemorrhage, from which he died; and at autopsy he was found to have severe hemochromatosis. If I remember correctly, he had no evidence at that time of diabetes or other damage to his pancreas, and he had no disturbance in pigmentation.

Dr. J. F. Wepfer (Radiologist): We have three films on this man. I think the chief film of interest is the one of the chest, where we see moderate enlargement of the heart due to hypertrophy of the left ventricle. Here we see calcification in the ascending arch of the aorta. Considerable calcification is also present in the descending thoracic aorta. The involvement of the ascending portion of the aorta presents the possibility of lues. At the time this particular film was taken, no significant degree of heart failure was evident, since pulmonary vascularity is certainly within normal limits.

On the film of the abdomen we see generalized haziness, which results in loss of soft tissue differentiation. This is due to fluid. The hepatic enlargement is not prominent inasmuch as we see the hepatic flexure here. There is no evidence of bowel obstruction.

Doctor Altshuler: The final anatomic diagnoses were:

1. Hemochromatosis
   (a) Hemochromatosis heart disease
   (b) Heart failure (clinical)
   (c) Cardiomegaly (500 Gm.)
   (d) Portal cirrhosis
   (e) Hepatoma
   (f) Diabetes (clinical)
   (g) Hemochromatosis pancreatic disease
   (h) Involvement of adrenal and lymph nodes
2. Acute passive pulmonary congestion
3. Pulmonary emphysema
4. Gastroesophageal varices
5. Ascites (3,000 cc.)
6. Postoperative subtotal gastrectomy with gastrojejunostomy, remote (seven years).

Doctor Rosenthal: Would there be excessive calcification if the parathyroids were involved and there was impairment in function?

Doctor Altshuler: To my knowledge, calcification occurs only in the basal ganglia in hypoparathyroidism. I rather doubt that it would be a feature here. This is an example of the dystrophic type of calcification rather than of the metastatic variety.

Doctor Rosenthal: Did you examine the parathyroids?

Doctor Altshuler: No, we didn't.

Doctor Rosenthal: You are now in a difficult position to argue.

Doctor Altshuler: No, I don't think we are inasmuch as hypoparathyroidism doesn't cause remarkable tissue calcification. Even if there were hyperparathyroidism, the calcification would be expected to be prominent in the stomach, lung, and kidney, in those areas where acid is produced.

APPROXIMATE COMPOSITION OF THE IRON-CONTAINING COMPOUNDS IN THE HUMAN (70 KILO MAN)

Compounds	*g.*	*Fe in g.*	*Per cent of total Fe*	*Reference No.*
Iron porphyrin (heme) compounds:				
Blood hemoglobin	900	3.0	60-70	(2)
Muscle hemoglobin (myoglobin)	40	0.13	3.0-5.0	(1, 2)
Heme enzymes:				
Cytochrome c	0.78	0.004	0.1	(2)
Cytochrome a_3, b	—	—	—	
Catalase	—	—	—	
Peroxidase	—	—	—	
Non-heme iron compounds:				
Iron monomolecularly dispersed:				
Ferrous ion	—	—	—	
Siderophilin (Fe+++)	10.0	0.004	0.1	(4, 5, 6, 10)
Iron in micellar ferric hydroxide units:				
Ferritin	2.0-4.0	0.4-0.8	15	(7, 8)
Non-crystallizable ferritin	—	—	—	(7, 8)
Hemosiderin	—	—	—	(7, 8)
Total Iron		4—5	100	(1)

Figure 1.

May I show this chart? (Fig. 1). It is taken from Granick's article[2] and indicates the normal distribution of the iron in the body. A 70 kilo man has approximately 3 to 5 Gm. of total body iron. Of this, most is in the heme compounds such as hemoglobin, catalase, cytochrome, and so on. The non-heme compounds are indicated on the lower half of the chart. Siderophilin or transferrin is the iron-binding protein that Doctor Rosenthal mentioned. The ferritin is the storage form of iron. It also is believed to participate in the absorption of iron, and it may be identical with the so-called vasodepressor material (VDM) of Shorr, a substance of interest in the pathogenesis of shock. Ferritin is somehow related to hemosiderin deposits in the tissue. It is an interesting protein. Twenty-three per cent of its dry weight is composed of iron in the form of ferric hydroxide clusters. It has the interesting property of being crystallizable from solutions by means of cadmium sulfate.

Here is a slide showing the crystals of ferritin. The protein carrier, free of iron, may also be crystallized by cadmium sulfate. This iron-free protein carrier is called apoferritin.

Figure 2 is a diagram of the current theory of the mechanism of iron absorption. To the left one can see the gastrointestinal tract, and here we see that iron is absorbed in the ferrous state. Thus, gastrointestinal or nutritional factors may be associated with decreased iron absorption. Here in the cell the ferrous iron combines with apoferritin to form ferritin, and in this process the iron is oxidized to the ferric form. Notice that phosphate is also precipitated at the same time. Then the iron is reduced and leaves the cell again in the ferrous state. It combines with the protein (siderophilin) to form a stable compound at body pH's, and here again it is in the ferric state. Normally, the serum iron level is about 120 micrograms or 120 gamma per 100 ml.; and the iron-binding

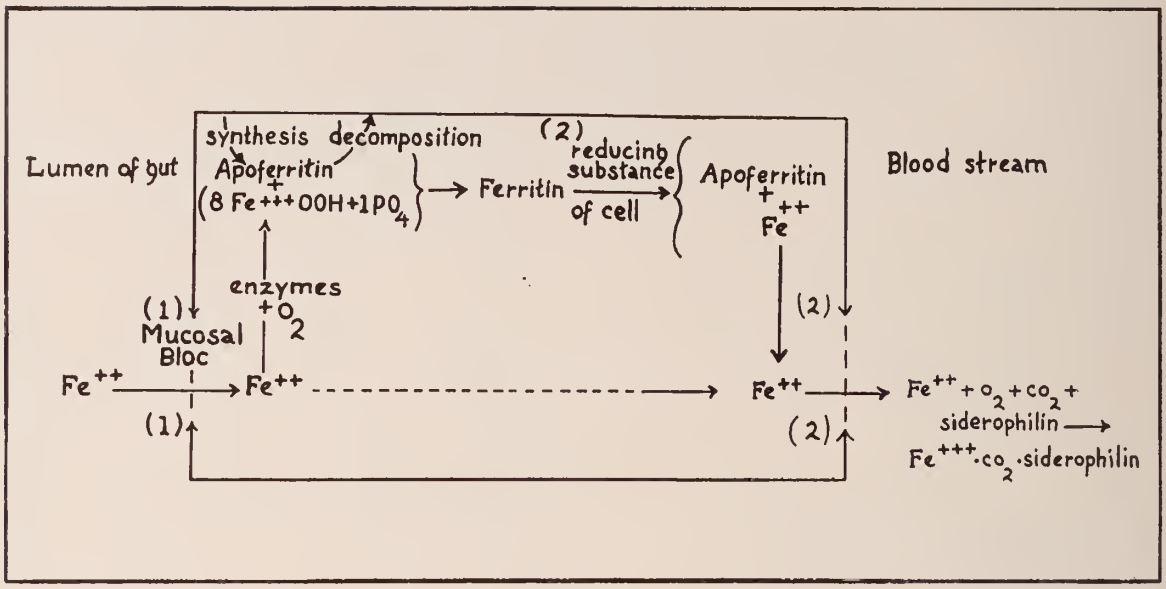

Figure 2.

protein or the siderophilin is found to be about one-third saturated.

The simultaneous determination of the serum iron and the iron-binding protein is said to be a sensitive index of the need of the body for iron and in certain instances may give important information as to the status of the body iron.

In Figure 3, the normal serum iron is seen to be 120 gamma, and there is about 200 gamma of siderophilin. That is, we say there is 200 gamma of siderophilin; but what we actually mean is that there is enough free iron-binding protein to combine with 200 more gamma of iron. Notice that in an uncomplicated iron deficiency anemia, the serum iron is only 30 gamma and the iron-binding protein is present in sufficient quantities to combine with 400 gamma of iron. Thus, in instances in which there is actual decrease in total body iron (iron deficiency anemia) the serum iron is low and the unsaturated iron-binding protein is high. In situations such as pernicious anemia where the body apparently needs a great deal of iron but the bone marrow is unable to use it, the serum iron will be high and the iron-binding protein will be low.

In hemochromatosis, you see that the serum iron is very high; it may go up to 225 gamma. The iron-binding protein is very low. This is also true in so-called transfusion hemochromatosis or exogenous hemochromatosis.

Recently, other interesting work, done with radioactive iron, gives us insight into the physiology of iron metabolism. The radioactive element is given intravenously, and the biologic half-life is determined. In the normal individual it is found to be about 110 minutes. The rate of disappearance from the serum is a matter of minutes. The rate is believed to be related to erythropoietic activity. In instances of increased erythropoiesis, the biologic half-life of the radioactive iron in the serum will go down to between 11 and 30 minutes; and in cases of decreased erythropoiesis, the half-life goes up to high levels. In aplastic anemia, for example, it may be about 250 minutes.

Dr. G. W. Sengpiel: I'd like to dispute that. The half-life of any radioactive element is always the same.

Doctor Altshuler: You are correct. I did not, of course, mean to use the term "half-life" in the sense that there is a decrease in the activity of the radioactive substance. I meant to define the time it takes to reduce the radioactivity in the serum to one-half its original value.

The liver was not grossly nodular, but microscopically it was similar to that of portal cirrhosis. One large hemorrhagic area was a hepatoma. Thus, a primary liver cancer did develop. Interestingly, this is a relatively common tumor among the Bantu Africans and certain Orientals and is apparently due to poor nutrition; there is inges-

Absorption, Transport and Utilization of Iron

Condition	Intestinal absorption of Fe	Fe-transferrin =O= serum iron in µg per 100 cc. serum	Transferrin not chelated with iron =O= LIBC* in µg per 100 cc. serum	Fe utilization for hemoglobin synthesis	Fe stores in liver	Life span of erythrocyte
I. Normal	1-2 mgm per day	120 µg (50-150)	200 µg (150-250)	20-25 mg/day	0.5-1.0 g	120 days
II. Uncomplicated iron deficiency anemia	high 2-10 x normal	30	400	high	low	normal
Pernicious anemia	high	200	50	low	high	low
Refractory hypoplastic anemia	high	200	50	low	high	
Pyridoxine deficiency anemia		high		low	very high	
Hemolytic anemia	high			high	high	low
Prolonged phenyl hydrazine induced anemia	high			high		low
Cobalt induced polycythemia	high?			high		
III. Anemia of acute infections	low	50	150	low	high	
Turpentine sterile abscess	low					
Acute hepatitis (2nd-5th week)		200	100			
Copper deficiency anemia	low	low		low	high	
IV. Hemochromatosis	high	225	25	normal	extremely high	normal
Increased iron stores as in transfusion hemosiderosis	low	225	25	normal	extremely high	normal

* LIBC = liberated iron binding capacity.

Figure 3.

tion of incomplete proteins, as Doctor Rosenthal has stated.

On microscopic examination, excessive deposits of pigment were observed in the pancreas, liver, and heart. Little pigment was observed in the adrenal, but there was a great deal in the heart; and we believe, as did Doctor Rosenthal, that the patient's hemochromatosis contributed significantly to his heart failure.

It is well to remember that we shouldn't be too hasty in cramming a particular case into a convenient pigeonhole before we have actually studied it satisfactorily—classifying a case of heart disease as arteriosclerotic heart disease, or as arteriosclerotic hypertensive heart disease, for instance, without having made a thorough study of the situation. I think Dr. Soma Weiss brought this out graphically in an article on scleroderma heart disease.

Are there any questions?

Doctor Karr: Yes, I'd like to ask Doctor Jurishica, who is interested in experimental surgery, whether he thinks there would be any benefit in doing surgery on the gastrointestinal tract, say a partial bowel resection, to decrease iron absorption in these patients. I've seen a number of patients who have had bowel surgery done and who developed anemia.

Dr. A. J. Jurishica: I'm glad that Doctor Karr asked the question because it really never occurred to me; but I should think if one were going to do anything in the way of therapy, he would probably want to use phlebotomies, which are so much simpler. However, the problem really ought to be investigated. Some of these patients probably have had gastric resections for some reason or another, and it would be interesting to see what happened to their hemochromatosis.

Doctor Altshuler: I don't like to be discouraging; but it seems to me that by the time the patient's condition is recognized clinically, the damage has already been done. I think the goal should be to do something to get rid of the pigment already there or to try to reverse whatever process is reversible rather than trying to prevent further absorption. Certainly, if one could prevent further absorption easily, I'd say that would be the thing to do; but I don't know whether doing something as heroic as resecting part of the bowel would be indicated, especially since the amount absorbed per day is so small. With regard to therapy, iron, of course, has a marked propensity to join in chelate com-

pounds. I know that some of the chelating agents have been recommended and have been used experimentally. I wonder whether any of the gentlemen present has had experience with their use. I am referring to drugs like ethylenediamine tetra-acetic acid (Versene) or some of the other chelating compounds.

(No response).

Doctor R. S. Cline: May I ask a question?

Doctor Altshuler: Certainly.

Doctor Cline: Has anything been done to see if the blood iron is elevated in the children of this patient?

Doctor Altshuler: As far as I know, nothing has been done. Doctor Coffey could probably be more informative.

Doctor Coffey: Not as far as I know.

Doctor Rosenthal: It would be an interesting and perhaps worth-while thing to do.

Doctor Altshuler: I'm sure it could be arranged because the patient's son-in-law is a doctor.

Doctor Karr: If we could establish an early diagnosis before the pigment has been deposited in the essential organs, then the factor of surgery might be considered.

Doctor Altshuler: Yes, I think under those conditions, it might be a good procedure.

Doctor Jurishica: Wouldn't one phlebotomy a month be adequate?

Doctor Altshuler: You mean for one of the affected members of the family.

Doctor Jurishica: Yes.

Doctor Altshuler: I suppose it might be. Of course, these are all conjectures. As far as I know, nobody has done this sort of thing; and we don't know how many phlebotomies would be necessary to keep these people in "normal" iron balance.

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Scientific Program

WISCONSIN CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

Hotel Schroeder, Milwaukee, May 1, 1955

12:00 Noon

Business Luncheon, Parlor A, 4th Floor

Scientific Program, East Room, 5th Floor

1. "Clinical Aspects of Pleurisy With Effusion"
   Jay A. Myers, M. D., Minneapolis, Minnesota
2. "The Prognosis of Bronchiectasis"
   A. M. Olsen, M. D., Rochester, Minnesota
3. "The Appraisal of the Routine Treatment of Bronchial Asthma"
   George L. Waldbott, M. D., Detroit, Michigan
4. "Rheumatic Heart Disease is Preventable"
   Chester M. Kurtz, M. D., Madison, Wisconsin
5. "Therapeutic Implications of Pulmonary Function Studies"
   H. A. Andrews, Jr., M. D., Chicago, Illinois
6. "Advantages Derived From Routine Chest X-Ray Examination In A General Hospital"
   Abraham Melamed, M. D., Milwaukee, Wisconsin

Hemorrhage in Pregnancy*

PART I

SINCE the maternal mortality survey was inaugurated in Wisconsin, the Study Committee has had the opportunity of reviewing the data on 66 maternal deaths. Important and instructive data have been accumulated by the committee, and the members of the committee feel that the study has been of practical value in focusing attention upon areas where obstetrical problems exist.

Of the maternal deaths intensively studied, 39 were due to purely obstetrical complications of pregnancy. Nearly 50 per cent of these 39 mothers died of acute obstetrical hemorrhage. It is important, statistically, to know that hemorrhage is the leading cause of maternal deaths in our state; but it is also necessary for all physicians practicing obstetrics to be aware of this fact if effective answers to the problem are to be found.

The survey has shown that the 18 deaths from obstetrical hemorrhage in the current series occurred either in the first or the third trimester of pregnancy. Ectopic pregnancies in the first trimester and ruptured uteri in the third proved to be the conditions responsible for the large majority of these hemorrhagic deaths. Since maternal hemorrhage confronts the profession as one of its most overwhelming problems, a brief review of the common causes of hemorrhage as it has occurred in this series may be helpful.

Bleeding Early in Pregnancy

Bleeding in pregnancy is never normal. Whenever it occurs, it should alert the physician and also the patient to the possibility of a developing complication which may prove to be serious. When it occurs, it is mandatory that the physician discover its source.

Abortion, in its various forms and with an incidence of 25 per cent, is a common serious complication of early pregnancy. In early pregnancy bleeding, a differential diagnosis of threatened abortion and implantation bleeding should be considered. According to recent studies by Speert and Guttmacher,[1] physiological bleeding associated with implantation and erosion of the endometrium by the trophoblast usually occurs about the time of the first missed menstrual period. This bleeding may be microscopic or may simulate the proportions of true menstrual bleeding. It is usually abrupt in onset and of short duration in contrast to an abortion, where bleeding begins slowly but increases in proportion and is associated with a greater flow of blood, clotting, and uterine cramping.

In the management of incomplete abortions with bleeding, this study has indicated that early diagnosis, hospitalization, and blood replacement are most essential. Fatalities occur because of several factors, among them delay in patients seeking aid, delay in blood replacement, and procrastination on the part of the attending physician in attacking the problem before the processes of secondary hemorrhage, with its accompanying irreversible shock, make the prognosis hopeless.

It is necessary that an adequate physical examination of patients with a bleeding history be made. This should include a pelvic examination as well as a blood study. The cause of the bleeding can almost always be determined and therapy applied. If the bleeding is active and especially if the history suggests an impending hemorrhage from an abortion, the pelvic examination, including speculum visualization of the cervix, should be done after admission to the hospital, where all preparations for the control of the hemorrhage can be adequately managed. In the management of obstetrical hemorrhage, this study has emphasized repeatedly the value of awareness on the part of the attending physician and the hospital personnel of the possibilities of fatalities from sudden and profuse abortal hemorrhages.

The problem of missed abortions has presented itself in our series. The management of such cases is complicated at times by a severe degree of sensitization to the Rh factor and the intrauterine death of the fetus in the antepartum period. A maternal death did occur in this series from a postpartum hemorrhage in a patient having this combination of circumstances. In reviewing the case, the committee members felt that

* Prepared for the Study Committee of the Wisconsin Maternal Mortality Survey by Alice D. Watts, M. D., Milwaukee.

the death was in all probability due to a disturbance in the blood coagulation mechanism, and the case seemed clinically to conform to the syndrome now currently known as afibrinogenemia. The defibrination of the blood which occurs in this syndrome is rather sudden in onset and can lead to a rapid and fatal termination if measures are not taken to combat the defibrination process. It is well, again, for physicians to be aware of this possibility and to obtain fibrinogen, as well as suitable blood for blood replacement and therapy, in advance of delivery. Details as to diagnosis of the syndrome and a method of determining the stability of the blood clot have been elaborated by Hodgkinson and Margulis[2] and by Duncan Reid *et al.*[3] in recent obstetrical literature. This problem of a macerated stillborn infant in an Rh sensitized mother presents a syndrome which seems very new; however, if we were to look in retrospect at cases of difficult hemorrhagic deaths where the etiology has been obscure, we might well find this syndrome as a causative factor.

In the current series of maternal deaths, the Study Committee has reviewed three deaths occurring as a result of ectopic pregnancies. Two of these deaths were due to prolonged hemorrhage, leading to irreversible shock. The third death was thought to be an anesthetic death following a posterior cul de sac puncture. In these hemorrhagic deaths, the diagnosis of the tubal ruptures had correctly been made. This is of interest since the usual difficulty in the management of ectopic pregnancies is one of early and proper diagnosis. Patient delay in seeking medical attention, language difficulties, and obesity contributed partially to the fatal outcomes in this series. In these cases of obstetric hemorrhage, blood, rather than glucose and saline, should be used; and operative procedures for the correction of the internal hemorrhage should be instituted immediately. In spite of blood transfusions, shock from a ruptured ectopic pregnancy deepens progressively until the blood loss is controlled by operative measures.

(The final part of this paper will be published in the May issue of the Journal.)

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UPPER PENINSULA MEDICAL SOCIETY CONVENTION AT LAND O'LAKES

On June 17 and 18, the Upper Peninsula Medical Society Convention will be held at the Gateway Hotel, Land O'Lakes, Wisconsin. Wisconsin physicians are especially invited to this meeting.

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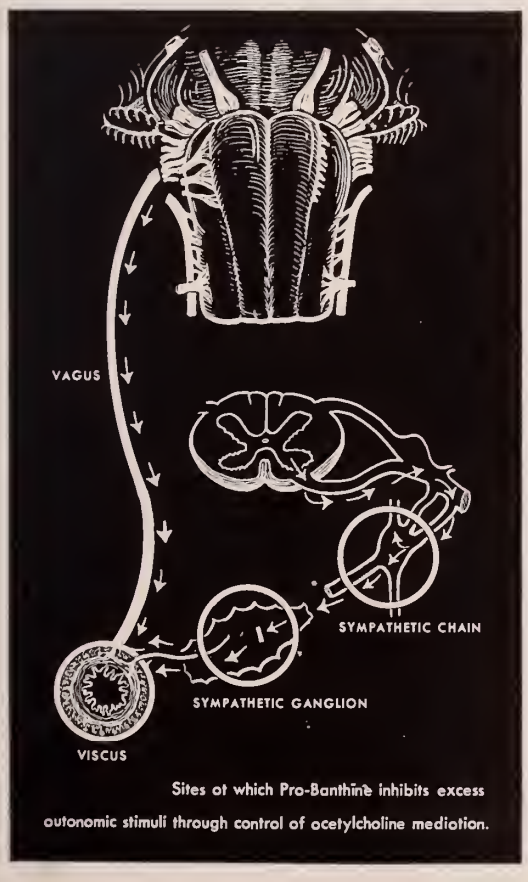

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OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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Volume 54 APRIL 1955 Number 4

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Editorial*

After the many defeats, and the two victories, that the AMA and every physician suffered at the hands of the Eisenhower Administration during the last two years, one wonders at the apathy, not only in the individual physician, but also in some of our officials.

The AMA won two battles which may be turned against us yet. First win came in keeping the physicians off the "Social Security" rolls, thanks to a kindly tip-off from one of our Congressmen. That victory was, by far, the greatest, and sparked by our own President Brooksher and Executive Secretary Paul Schaefer who drew hundreds of telegrams of protest from physicians and AMA officials in every state.

The second win came in defeating the Reinsurance Program, about the most useless piece of legislation that had the Eisenhower backing. It is strange, indeed, that the President, as late as August 23 of this year, should be still insisting on such legislation.

Probably the worst of our defeats came when Section 106 of the Social Security code was adopted over the efforts of a few of our physician leaders like Francis J. L. Blasingame, of Wharton, Texas, who saw its insidious features. This particular battle was lost because not enough of our leaders saw through the camouflage, and the opposition was of the "too little and too late" variety.

The Washington Office has warned us that the President is cooking up a stew to force the Reinsurance Program down our throats, and we might be ready. We might also organize a repeal of Section 106 of the SS Act, so that the Drs. can be taken off Mrs. Hobby's hook, though repeal will mean that every member of the House of Congress will have to be contacted by some physician in his home town. This work should be in the process of organization now. It should be done while our Representatives are at home feeling out the sentiment. The Washington office of the AMA can be our "listening post," but the real influence is from some private physician at home.

A united front by physicians on legislators is a powerful force. One doesn't have to be in Washington, or even out of his office, to talk to his Congressman, and reflect to him the thinking of the sounder element of our country.

There should be plans among our Medical leaders now to repeal Section 106, to promote the Bricker amendment, to curb the "give away" program that Eisenhower adopted from the Truman Administration, and to aid other professional groups, engi-

* Reprint from The Journal of the Arkansas Medical Society, November, 1954.

neers, etc. in getting out from the onus of the Social Security tax and dole. The engineers realized belatedly that they forgot to fight for liberty. Perhaps some spark of hope can be raised for them if physicians keep alert, organize for strength and carry the battle by attack instead of being defeated by no defense. The fight for liberty was not made alone at Bunker Hill. It is being made today.

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HENRY A. ANDERSON, M. D.
Chairman, Division on
Tuberculosis and Chest
Diseases, State Medical
Society of Wisconsin

. . . . THE PRESIDENT'S PAGE . . . .

THE vast majority of the members of the medical profession, by the very nature of their work, do not have too many outside interests. The practice of medicine requires spending long hours, always being on call, and reading of medical literature during spare time. All this results in the doctor's time being pretty well taken up by his professional duties.

The events of the last 20 or 25 years, however, emphasize to the members of our profession a responsibility that is of tremendous importance—that of citizenship. The reason why medical leadership is constantly trying to arouse the members of the medical profession to take an interest in their civic duties is that government has undergone a profound change in its philosophy and there has been a steady encroachment on the rights and privileges of its citizens.

Medicine has met this challenge to the liberty of the individual citizen and will continue to do so; however, it needs the interest and help of everyone in the profession, both as individuals and as members of its various societies. Medicine will progress to the extent that it exists in a favorable environment and will suffer to the extent that government encroaches upon it.

The present Congress is considering proposed legislation that has far-reaching implications. Because we have special knowledge of medicine gained through our education and experience, there is placed upon us the obligation to examine the effect for good, or otherwise, of the legislation proposed. Having examined the legislation, it is our duty to become acquainted with the position of the State Medical Society and the American Medical Association so that our expressions to those outside the profession are made in full knowledge of official attitudes. It is imperative that members of the medical profession interest themselves in these matters, that they find out from their Society officers and other sources what measures the lawmakers have before them, and that they give these measures thought and study.

As I said before, and repeat for emphasis, we as members of the medical profession are the only ones who can really determine the possible effects of the measures proposed and the extent to which they may influence the health and welfare of American citizens.

As has been so aptly said, physicians were citizens before they were doctors and they must continue to exercise the duties of citizenship. There is too much at stake for the American people for them to do otherwise.

Arthur J. McCary M.D.

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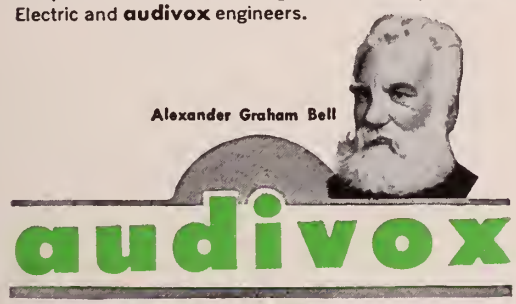

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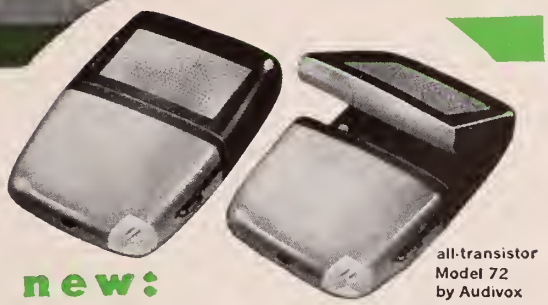

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Society Proceedings

Ashland–Bayfield–Iron

Twelve members of the Ashland–Bayfield–Iron County Medical Society met on February 16 at the Menard Hotel, Ashland. *Dr. C. M. Ihle* of Eau Claire discussed "Treatment of Fractures in Children." A question-and-answer period followed.

Brown–Kewaunee–Door

The regular meeting of the Brown–Kewaunee–Door County Medical Society was held on March 10 at the Elks Club, Green Bay, with dinner served at 7:00 p.m.

Dr. Donald M. Ruch, assistant clinical professor of dermatology at Marquette University School of Medicine, spoke on "Dermatologic Conditions Commonly Seen in Office Practice."

Chippewa

Dr. Robert C. Parkin, coordinator of postgraduate medical education at the University of Wisconsin Medical School, addressed the members of the Chippewa County Medical Society on March 8 in Chippewa Falls.

The title of his talk was "Future Trends in Medical Education."

Dane

The Dane County Medical Society held its monthly meeting on March 8 at the Madison Club, Madison. The program was devoted to a discussion of the Madison and Dane County welfare program, with *Dr. C. O. Vingom* of Madison, coordinator of the program, leading the discussion. Other speakers were Mr. A. T. Zoeller, director of the Dane County Public Assistance program, and Mrs. Betty Hurst of the Madison Welfare Agency.

Fond du Lac

Thirty-four members of the Fond du Lac County Medical Society met on February 24 at the Elks Club, Fond du Lac. *Dr. M. S. Kagen* of Appleton spoke on "Common Errors in Dermatological Diagnosis." Discussants were *Dr. J. C. Swan* and *Dr. J. C. McCullough* of Fond du Lac.

A committee was formed to meet with the city relief department with regard to payment for services rendered to pension patients.

Dr. Harold E. Martin of Fond du Lac was chosen as the society's orthopedic surgical consultant to the Crippled Children's Clinic.

Green Lake–Waushara

Members of the Green Lake–Waushara County Medical Society met at the Hotel Whiting, Berlin, on February 24, to hear an address by *Dr. E. C. Albright* of Madison. He spoke on "Radioactive Iodine and Treatment of Thyroid Disease."

Doctor Albright is an assistant professor of medicine at the University of Wisconsin Medical School and consultant in endocrinology to the Veterans Hospital in Madison.

During the business meeting which followed, a rheumatic fever clinic was scheduled for June 8, a maximum fee of $2 was approved for examinations of the Home Guard, dispensing of medicine was discussed, examinations of school children were discussed, and *Dr. F. G. Slattery* of Wautoma was appointed to the Health Committee.

Kenosha

Eighteen members of the Kenosha County Medical Society visited three manufacturing plants in that community on February 16 as part of the Kenosha Manufacturers' Association employee safety and health program.

On March 3, 49 of the members met at the Elks Club, Kenosha, to hear a discussion of medicolegal problems by Mr. C. H. Crownhart, secretary of the State Medical Society, Madison, and Mr. Robert B. Murphy, legal counsel, Madison.

The society voted to continue visits to various industries in the community.

Manitowoc

At the March meeting of the Manitowoc County Medical Society, Dr. Cleveland J. White, professor and chairman of the Department of Dermatology, Stritch School of Medicine, Loyola University, Chicago, was the guest speaker. He discussed "Newer Methods of Treatment in the More Common Diseases of the Skin."

The meeting was held on March 24 at the Hotel Manitowoc, Manitowoc.

Marinette–Florence

Dr. B. H. Glover, assistant professor of psychiatry at the University of Wisconsin Medical School, Madison, addressed a joint meeting of the Marinette and Menominee medical societies on February 16 at St. Joseph–Lloyd Hospital, Marinette. His topic was "Anxiety."

Oconto

Eight members of the Oconto County Medical Society met informally at the Alamo Club, Stiles, on

February 15. The speaker who had been scheduled was unable to be present because of a severe snow storm.

Outagamie

The Outagamie County Medical Society met on February 17 at the Elks Club, Appleton. *Dr. C. H. Kalb* of Milwaukee spoke on "Clinical Problems in the Management of Allergic Children."

A resolution was passed by the society that if the community decides to build another hospital, the Outagamie County Medical Society would support it as individuals of the community and as a profession. *Dr. Paul M. Cunningham* of Appleton, chairman of the Hospital Committee, reported on the progress of the plans and fund-raising campaign for the proposed new Appleton Memorial Hospital.

Pierce–St. Croix

On February 15 the Pierce–St. Croix County Medical Society held its monthly meeting at Hudson. Dr. Joseph W. Goldsmith, Jr., of St. Paul discussed "Diseases of the Ovary." He gave special emphasis to the latest methods of diagnosis and treatment of these conditions.

Polk

Meeting as guests of *Dr. L. O. Simenstad* of Osceola, 16 members of the Polk County Medical Society gathered at the Paradise Lodge at Balsam Lake on February 17.

Dr. James F. Shandorf of Minneapolis addressed the group on a recent study of eclampsia. A round table discussion followed.

Rock

Members of the Rock County Medical Society met on February 22 to hear a talk by *Dr. Henry Suckle* of Madison. He discussed "Brain Tumors in Childhood and Hydrocephalus."

Trempealeau–Jackson–Buffalo

Dr. Paul C. Dietz, pathologist at St. Francis Hospital, La Crosse, addressed the members of the Trempealeau–Jackson–Buffalo County Medical Society on February 22. The meeting was held at the Eagle Hotel, Galesville.

Doctor Dietz discussed the use of the laboratory in general practice.

Walworth

The Walworth County Medical Society met on February 10 at the Trayer Hotel, Lake Geneva. Fifteen members were present.

Dr. Kenneth E. Lemmer, associate professor of surgery at the University of Wisconsin Medical School, Madison, spoke on "Acute Abdomen in Pediatrics." An informal group discussion followed.

Plans for a meeting of the Racine, Kenosha, and Walworth County medical societies were discussed.

Winnebago

Members of the Outagamie County Medical Society were invited to a dinner meeting of the Winnebago County Medical Society at the Valley Inn, Neenah, on March 3.

Dr. William Hildebrand, Menasha, national president of the Academy of General Practice, discussed timely subjects such as the Veterans Administration, refugee physicians, prepaid insurance, and the accreditation of hospitals.

Wood

Election of officers was held at the meeting of the Wood County Medical Society on January 27 at the Hotel Charles, Marshfield. Those elected were:

President—*Dr. G. L. McCormick*, Marshfield
Vice-President—*Dr. E. C. Glenn*, Wisconsin Rapids
Secretary—*Dr. N. J. Helland*, Marshfield
Delegate—*Dr. R. W. Mason*, Marshfield

Dr. C. R. Montz, Marshfield, presented a paper entitled "The Use of the Male Hormone in the Treatment of the Diseases of the Female."

Milwaukee Neuro-Psychiatric Society

The Milwaukee Neuro–Psychiatric Society met at the University Club, Milwaukee, on March 16, at which time three guest speakers appeared.

Dr. C. F. Midelfort of the Gundersen Clinic, La Crosse, spoke on "Use of Family in Therapeutic Interviews with Patients"; *Dr. Keith M. Keane*, Sheboygan Clinic, Sheboygan, discussed "Intravenous Sodium Amytal and Cortical Stimulants as Adjuncts in Psychotherapy"; and *Dr. Henry M. Suckle* of Madison spoke on "Carotid Ligation and the Treatment of Intracranial Aneurysms."

Milwaukee Academy of Medicine

Dr. W. G. Bigelow of Toronto, Canada, addressed the members of the Milwaukee Academy of Medicine at their March 15 meeting at the University Club, Milwaukee. His talk was entitled "The Effect of Hypothermia upon the Risk of Surgery."

A special clinic was held on March 16 at the Milwaukee Children's Hospital amphitheater.

Milwaukee Oto-Ophthalmic Society

A meeting of the Milwaukee Oto–Ophthalmic Society was held on February 22 at the Milwaukee University Club. Dr. Joseph Haas of the Illinois Eye and Ear Infirmary, Chicago, spoke on "Combined Glaucoma."

Wisconsin Surgical Club

The Wisconsin Surgical Club made its annual trip from February 28 through March 5. The group visited Cincinnati, Columbus, and Cleveland, Ohio.

HOUSE OF DELEGATES—1955

CRYSTAL BALLROOM, HOTEL SCHROEDER — Tuesday, May 3, 7:30 p. m., First Session — Wednesday, May 4, 7:30 p. m., Second Session — Thursday, May 5, 8:30 a. m., Third Session

SPEAKER: L. O. Simenstad, M. D., Osceola — VICE-SPEAKER: J. W. Fons, M. D., Milwaukee

FIRST DISTRICT

Counties	Delegates	Alternates
DODGE	A. B. Kores	L. W. Schrank
JEFFERSON	F. A. Gruesen	R. W. Quandt
WAUKESHA	M. J. Werra	W. D. James

SECOND DISTRICT

KENOSHA	D. N. Goldstein	Louis Olsman
RACINE	G. J. Schulz	R. J. Schacht
	L. O. Mastalir	J. D. Postorino
WALWORTH	E. D. Sorenson	E. D. Hudson

THIRD DISTRICT

COLUMBIA-MARQUETTE-ADAMS	J. H. Houghton	R. F. Inman
DANE	L. E. Holmgren	J. R. Steeper
	M. T. Morrison	I. A. Grab
	T. W. Tormey, Jr.	R. M. Becker
	C. W. Stoops, Jr.	R. P. Sinaiko
	G. C. Hank	R. J. Hennen
	A. A. Quisling	John T. Sprague
GREEN	W. D. Stovall, Jr.	D. E. Mings
ROCK	Richard A. Thayer	W. J. Mauermann
	M. D. Davis	J. D. Schroeder
SAUK	J. F. Moon	J. J. Rouse

FOURTH DISTRICT

CRAWFORD	O. E. Satter	T. F. Farrell
GRANT	E. C. Howell	M. W. Randall
IOWA	C. L. White	S. B. Marshall
LAFAYETTE	L. L. Olson	R. E. Oertley
RICHLAND	D. J. Taft	R. E. Housner

FIFTH DISTRICT

CALUMET	E. W. Humke	A. C. Engel
MANITOWOC	E. C. Cary	R. G. Strong
SHEBOYGAN	P. B. Mason	F. A. Nause
WASHINGTON-OZAUKEE	E. C. Quackenbush	P. B. Blanchard

SIXTH DISTRICT

BROWN-KEWAUNEE-DOOR	L. C. Miller	P. F. Dockry
	R. M. Waldkirch	S. L. Griggs
FOND DU LAC	H. J. Kief	Howard Mauthe
OUTAGAMIE	G. W. Carlson	H. T. Gross
WINNEBAGO	R. H. Bitter	David Regan
	George Schwei	W. V. Hahn

SEVENTH DISTRICT

TREMPEALEAU-JACKSON-BUFFALO	R. L. Mac Cornack, Sr.	B. C. Dockendorff
LA CROSSE	R. L. Gilbert	R. W. Ramlow
MONROE	S. D. Beebe	Harry Mannis
VERNON	R. S. Hirsch	L. F. Gulbrandsen
JUNEAU	V. M. Griffin	J. S. Hess

EIGHTH DISTRICT

MARINETTE-FLORENCE	C. E. Koepp	I. W. Boren, Jr.
OCONTO	H. A. Aageson	F. E. Zantow
SHAWANO	A. A. Cantwell	H. C. Marsh

NINTH DISTRICT

Counties	Delegates	Alternates
CLARK	M. V. Overman	J. W. Johnson
GREEN LAKE-WAUSHARA	Russell Pelton	L. S. Shemanski
LINCOLN	R. G. Baker	K. A. Morris
MARATHON	E. P. Ludwig	D. M. Green
PORTAGE	F. E. Gehin	R. H. Slater
WAUPACA	M. A. Borchardt	W. G. Arnold
WOOD	R. W. Mason	W. L. Nelson

TENTH DISTRICT

BARRON-WASHBURN-SAWYER-BURNETT	J. R. Guy	R. C. Thompson
CHIPPEWA	W. C. Henske	J. J. Sazama
EAU CLAIRE-DUNN-PEPIN	R. C. Strand	Robert Lotz
PIERCE-ST. CROIX	P. H. Gutzler	O. H. Epley
POLK	L. O. Simenstad	V. C. Kremser
RUSK	L. M. Lundmark	H. F. Pagel

ELEVENTH DISTRICT

ASHLAND-BAYFIELD-IRON	J. W. Prentice	J. M. Jauquet
DOUGLAS	C. W. Giesen	C. J. Picard

TWELFTH DISTRICT

MILWAUKEE	I. J. Ricciardi	H. J. Lee
	E. R. Daniels	E. P. Bickler
	F. E. Drew	G. E. Collentine, Jr.
	J. W. Fons	J. E. Conley
	J. P. Conway	A. F. Tessier
	J. V. Herzog	D. V. Elconin
	S. W. Hollenbeck	M. S. Fox
	W. J. Houghton	P. F. Hausmann
	G. S. Kilkenny	G. W. Hilliard
	L. P. Stamm	R. L. Rice
	C. A. H. Fortier	I. D. Reifenrath
	A. J. Baumann	E. A. Habeck
	J. B. Wilets	R. E. Callan
	R. F. Purtell	D. W. Ovitt
	S. L. Chojnacki	S. E. Zawodny
	P. J. Niland	R. T. McCarty
	A. G. Martin	A. J. Sanfelippo
	D. M. Willson	E. M. End
	J. M. Beffel	M. C. F. Lindert
	S. A. Morton	C. M. Schroeder

THIRTEENTH DISTRICT

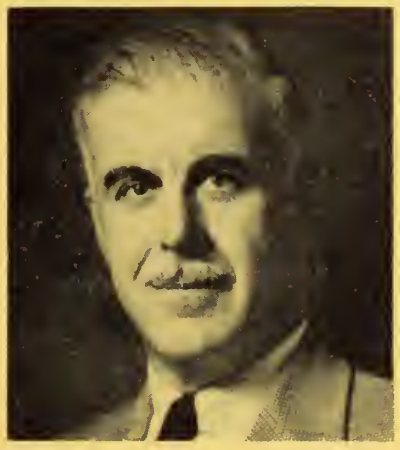
FOREST	E. F. Castaldo	B. S. Rathert
LANGLADE		
ONEIDA-VILAS	Marvin Wright	I. E. Schiek, Sr.
PRICE-TAYLOR	J. D. Leahy	W. E. Niebauer

SECTIONS

Section	Delegates	Alternates
GENERAL PRACTICE	E. J. Schneller	C. G. Reznichek
INTERNAL MEDICINE	R. N. Allin	R. A. Frisch
NEUROLOGY and PSYCHIATRY	Harry Tabachnick	E. Madison Paine
OBSTETRICS and GYNECOLOGY	F. J. Hofmeister	W. O. Paulson
OPHTHALMOLOGY and OTOLARYNGOLOGY	E. J. Zeiss	H. C. High, Jr.
ORTHOPEDICS	D. W. McCormick	F. G. Gaenslen
PATHOLOGY	Gorton Ritchie	R. S. Haukohl
PEDIATRICS	G. H. Wegmann	E. H. Pawsat
PUBLIC HEALTH	Milton Feig	C. K. Kincaid
SURGERY	I. M. Sullivan	M. G. Rice
RADIOLOGY	W. T. Clark	R. L. Troup
UROLOGY	J. W. Sargent	R. S. Irwin

Complete

1955 ANNUAL MEETING PROGRAM



The 1955 Annual Meeting scientific programs were prepared under the immediate direction of S. A. Morton, M. D., Milwaukee, in cooperation with the Council on Scientific Work and representatives of the Section on Ophthalmology and Otolaryngology.

Program Prepared by Council on Scientific Work

P. A. MIDELFART, M. D.
Eau Claire
Chairman

S. A. MORTON, M. D.
Milwaukee
Program Chairman

M. G. RICE, M. D.
Stevens Point
Assistant Program Chairman

L. G. KINDSCHI, M. D.
Monroe
Director, Scientific Exhibits

K. E. LEMMER, M. D.
Madison

J. S. HIRSCHBOECK, M. D.
Milwaukee
Dean, Marquette University School of Medicine

W. S. MIDDLETON, M. D.
Madison
Former Dean, University of Wisconsin Medical School

R. S. BALDWIN, M. D.
Marshfield
Medical Editor, Wisconsin Medical Journal

Condensed Time Schedule

SUNDAY, MAY 1

2:00 p. m.: Council Meeting; Club Rooms, Hotel Schroeder
6:30 p. m.: Council Dinner; Club Rooms, Hotel Schroeder

MONDAY, MAY 2

9:00 a. m.: Golf Tournament, Wisconsin Medical Golf Association; North Hills Country Club
6:30 p. m.: Golf Tournament Dinner and Awards

TUESDAY, MAY 3

9:00 a. m.: First Scientific Assembly; Juneau Hall, Milwaukee Auditorium
12:15 p. m.: Past Presidents' Luncheon; Parlor G, Hotel Schroeder
12:30 p. m.: Clinic Managers' Luncheon; Parlor A, Hotel Schroeder
1:00 p. m.: Round Table Discussions; Milwaukee Auditorium
2:00 p. m.: Section on Medical History; Room 4, Sports Arena, Milwaukee Auditorium
2:15 p. m.: Second Scientific Assembly; Juneau Hall, Milwaukee Auditorium
4:30 p. m.: Wisconsin Society of Internal Medicine; Parlor E, Hotel Schroeder
7:30 p. m.: First Session of the House of Delegates; Ballroom, Hotel Schroeder

WEDNESDAY, MAY 4

9:00 a. m.: Reference Committees; Fifth Floor, Hotel Schroeder
9:00 a. m.: Third Scientific Assembly; Juneau Hall, Milwaukee Auditorium
12:15 p. m.: Wisconsin Public Health M. D.'s Luncheon; Parlor H, Hotel Schroeder
1:00 p. m.: Round Table Discussions; Milwaukee Auditorium
2:30 p. m.: Fourth Scientific Assembly; Juneau Hall, Milwaukee Auditorium
6:00 p. m.: Buffet Supper for Delegates and Officers; East Room, Hotel Schroeder
7:30 p. m.: Second Session of the House of Delegates; Ballroom, Hotel Schroeder
9:30 p. m.: Civilian Defense Demonstration; East Room, Hotel Schroeder

THURSDAY, MAY 5

8:30 a. m.: Third Session of the House of Delegates; Ballroom, Hotel Schroeder
9:00 a. m.: Fifth Scientific Assembly; Juneau Hall, Milwaukee Auditorium
12:00 noon: Marquette Alumni Luncheon, Milwaukee Auditorium
12:15 p. m.: Luncheon and Program, Section on Ophthalmology and Otolaryngology, East Room, Hotel Schroeder
2:30 p. m.: Final Scientific Assembly; Juneau Hall, Milwaukee Auditorium
5:30 p. m.: President's Reception; East Room, Hotel Schroeder
6:30 p. m.: Dinner and Floor Show; Ballroom, Hotel Schroeder

Auxiliary Time Schedule

TUESDAY, MAY 3

6:30 p. m.: Board of Directors' Dinner; English Room, Hotel Schroeder

WEDNESDAY, MAY 4

9:30 a. m.: Business Meeting; Pere Marquette Room, Hotel Schroeder
1:00 p. m.: Luncheon; The Chalet on the Lake

THURSDAY, MAY 5

9:30 a. m.: Business Meeting; Pere Marquette Room, Hotel Schroeder
11:00 a. m.: Post-Convention Meeting of Officers; Parlor E, Hotel Schroeder
1:00 p. m.: Luncheon and Style Show; Ballroom, Hotel Schroeder

Announcements

REGISTRATION: Secure your badge at the registration desk, inside of main entrance of Milwaukee Auditorium, Kilbourn Street. Registration hours: Tuesday and Wednesday, 8:30 a.m.–4:30 p.m.; Thursday, 8:30 a.m.–3:00 p.m. **Admittance by badge only.**

CERTIFIED GUESTS: Medical students and hospital personnel admitted on Thursday, **if previously certified,** or presenting proper credentials. Residents and interns admitted without registration fee, if properly certified by hospital. Out-of-state physicians who are full dues-paying members of their county and state medical societies admitted by presenting their membership cards.

VA AND MD'S IN MILITARY SERVICE: Members of Veterans Administration must be full dues-paying members to be admitted. Those physicians in armed services admitted by presenting certification of current military service.

TELEPHONE SERVICE: At Milwaukee Auditorium— During scientific sessions, calls to physicians other than Milwaukee doctors should be directed to special phones installed at the registration desk. The number is Broadway 6–0775. Calls for Milwaukee doctors should be directed through Physicians Service Bureau (Broadway 1–4131), and they will be transmitted to a special phone in the Auditorium located near the main meeting room. A staff member of the Medical Society of Milwaukee County will be in attendance to receive the calls. **At the Hotel Schroeder—**Delegates can be reached during sessions of the House (Tuesday, May 3, from 7:30–10:00 p.m.; Wednesday, May 4, from 6:00–10:00 p.m.; and Thursday, May 5, from 8:30–10:00 a.m.) by having calls directed to the phone on the fifth floor foyer of the Hotel Schroeder (Broadway 1–7250).

RESERVATIONS FOR ROUND TABLES AND DINNER: Reservations for round tables and dinner at registration desk in Milwaukee Auditorium from 8:00 a.m.–4:30 p.m.

All reservations made in advance held until 10:00 a.m. the day of the round table. If not called for by that time, the ticket will be reissued.

Dinner tickets available at registration desk or at Hotel Schroeder (fifth floor foyer) between 5:30–6:30 p.m. on Thursday, May 5.

RELATED MEETINGS:

Sunday, May 1:

Wisconsin Chapter, American College of Chest Physicians; Hotel Schroeder. Luncheon at noon, scientific program starting at **1:30 p.m.** Those desiring luncheon reservations should contact Leon H. Hirsch, M.D., 238 West Wisconsin Avenue, Milwaukee 3.

Monday, May 2:

Golf Tournament. For reservations write Al Luthmers, Medical Society of Milwaukee County, Bankers Building, Milwaukee.

Tuesday, May 3:

12:15 p.m.: Past Presidents' Luncheon; Hotel Schroeder.

12:15 p.m.: Luncheon and Scientific Program, International College of Surgeons; Hotel Schroeder. Those desiring luncheon reservations ($3.00) should contact John Sprague, M.D., 109 East Johnson Street, Madison.

12:30 p.m.: Clinic Managers' Luncheon; Hotel Schroeder.

2:00 p.m.: Section on Medical History; Room 4, Sports Arena, Milwaukee Auditorium.

4:30 p.m.: Wisconsin Society of Internal Medicine; Parlor E, Hotel Schroeder. Business meeting. All internists urged to attend.

6:30 p.m.: Wisconsin Society of Obstetrics and Gynecology. Dinner, University Club. Speaker, Lowell Peterson, M.D., Presbyterian Hospital, University of Illinois College of Medicine, Chicago. For reservations write George Kilkenny, M.D., 945 North 12th Street, Milwaukee 3.

Wednesday, May 4:

12:15 p.m.: Wisconsin Public Health Physicians' Luncheon; Hotel Schroeder. Those wishing to attend should make their reservations through Margaret Hatfield, M.D., Elkhorn. Price $2.50.

6:30 p.m.: Wisconsin Academy of Pediatrics Dinner; University Club. Doctor Hill, Des Moines, as honored guest. Academy members wishing to attend should contact F. J. Mellencamp, M.D., 1513 East Capitol Drive, Milwaukee 11.

Thursday, May 5:

12:00 noon: Marquette Alumni Association Luncheon; Milwaukee Auditorium. For reservations write Mr. Ray Pfau, Marquette Alumni Association, 620 North 14th Street, Milwaukee.

Civilian Defense Demonstration

On Wednesday evening, May 4, immediately following the House of Delegates meeting, there will be a demonstration on civilian defense in the East Room, Hotel Schroeder, presented by the regional office of the Federal Civil Defense Administration, Peoria, Illinois. All physicians and their wives are invited to attend. Those who are members of medical teams, and county officers, are especially urged to attend this interesting and enlightening demonstration.

SCIENTIFIC SESSIONS

■ J. ARNOLD BARGEN, M. D.

■ IVAN BARONOFSKY, M. D.

■ EARL R. MILLER, M. D.

Tuesday, May 3

OPENING GENERAL SCIENTIFIC ASSEMBLY

Juneau Hall—Milwaukee Auditorium

Chairman: Arthur J. McCarey, M. D.

9:00 a. m.: GASTRIC ULCER: ITS DIAGNOSIS AND TREATMENT

Moderator: **L. J. Van Hecke, M. D.**, Milwaukee

Participants:

Frederick W. Madison, M. D., Clinical Professor of Medicine, Marquette University School of Medicine, Milwaukee

John L. Armbruster, M. D., Associate Clinical Professor of Radiology, Marquette University School of Medicine, Milwaukee

Forrester Raine, M. D., Clinical Professor of Surgery, Marquette University School of Medicine, Milwaukee

10:00 a. m.: RECESS TO VIEW EXHIBITS

10:45 a. m.: THE ROLE OF CORTISONE AND CORTICOTROPIN IN GASTROINTESTINAL DISORDERS: J. Arnold Bargen, M. D., Professor of Medicine, Mayo Foundation; Chief of Department of Gastroenterology, Mayo Clinic, Rochester, Minnesota

11:15 a. m.: ADENOMAS AND HEMORRHOIDS: PROBLEMS OF RECTAL BLEEDING: Robert Turell, M. D., Assistant Professor of Surgery, in Proctology, Albert Einstein Medical School, New York City

Round Table Discussions

1:00–2:00 p. m.: Auditorium

Rear of Juneau Hall: **REGIONAL ENTERITIS: PROBLEMS OF MANAGEMENT: J. Arnold Bargen, M. D.**, Rochester, Minnesota

Chairman: M. C. F. Lindert, M. D., Milwaukee

Room 1, Sports Arena: **ABUSES IN PROCTOLOGY: Robert Turell, M. D.**, New York City

Chairman: Carl W. Eberbach, M. D., Milwaukee

South Kilbourn Hall: **SUICIDE: John Romano, M. D.**, Rochester, New York

Chairman: Joseph A. Kindwall, M. D., Milwaukee

Room 2, Sports Arena: **PLANTAR WARTS AND CALLUSES: Donald M. Ruch, M. D.**, Assistant Clinical Professor of Dermatology, Marquette University School of Medicine, Milwaukee, and **Wallace C. Miller, M. D.**, Racine

SCIENTIFIC SESSIONS

Tuesday, May 3

SECOND GENERAL SCIENTIFIC ASSEMBLY

Juneau Hall—Milwaukee Auditorium

2:15–5:00 p. m.

Chairman: S. A. Morton, M. D., Milwaukee

2:15–3:00 p. m.: THE DOCTOR-PATIENT RELATIONSHIP: John Romano, M. D., Professor of Psychiatry, University of Rochester School of Medicine, Rochester, New York (Rogers Memorial Lecture, Rogers Memorial Sanitarium, Oconomowoc)

3:00–3:30 p. m.: UNJUSTIFIED GYNECOLOGICAL OPERATIONS: Richard TeLinde, M. D., Professor of Gynecology, Johns Hopkins University School of Medicine, Baltimore, Maryland

3:30–4:00 p. m.: RECESS TO VIEW EXHIBITS

4:00–4:30 p. m.: ESOPHAGEAL HIATUS HERNIA: ITS FATE AND TREATMENT: Ivan Baronofsky, M. D., Associate Professor of Surgery, University of Minnesota Medical School, Minneapolis

4:30–5:00 p. m.: THE PLACE OF X-RAY MOVIES IN MEDICINE: Earl R. Miller, M. D., Professor of Radiology, University of California Medical School, San Francisco

JOHN ROMANO, M. D.

RICHARD TE LINDE, M. D.

Round Table Discussions

1:00–2:00 p. m.: Auditorium

Room 3, Sports Arena: **THE POSTPHLEBITIC SYNDROME: James E. Conley, M. D.,** Assistant Clinical Professor of Surgery, Marquette University School of Medicine, Milwaukee

Walker Hall: **MEETING PROBLEMS OF HEMORRHAGE IN OBSTETRICS: Frederick J. Hofmeister, M. D.,** Assistant Clinical Professor of Obstetrics and Gynecology, Marquette University School of Medicine, Milwaukee

Special Luncheons

12:15 p. m.: Past Presidents' Luncheon: Parlor G, Hotel Schroeder

12:30 p. m.: Clinic Managers: Parlor A, Hotel Schroeder

ROBERT TURELL, M. D.

SCIENTIFIC SESSIONS

JOHN J. BONICA, M. D.

JAMES A. EVANS, M. D.

LEE FORREST HILL, M. D.

Wednesday, May 4

THIRD GENERAL SCIENTIFIC ASSEMBLY

Juneau Hall—Milwaukee Auditorium

9:00–10:00 a. m.: WHAT'S NEW IN MEDICINE:

Moderator: **L. G. Kindschi, M. D.**, Monroe

Participants:

Ivan Baronofsky, M. D., Minneapolis: Surgery
Richard TeLinde, M. D., Baltimore: Gynecology
Lee Forrest Hill, M. D., Des Moines: Pediatrics
Don H. O'Donoghue, M. D., Professor and Chairman, Department of Orthopedic and Fracture Surgery, University of Oklahoma School of Medicine, Oklahoma City: Orthopedics

10:00 a. m.: RECESS TO VIEW EXHIBITS

10:45–11:15 a. m.: Continuation of **WHAT'S NEW IN MEDICINE:**

Moderator: **M. G. Rice, M. D.**, Stevens Point

Participants:

Ovid O. Meyer, M. D., Madison: Drug Therapy (omitting hypertension)
John J. Bonica, M. D., Director, Department of Anesthesiology, Tacoma General Hospital, Tacoma, Washington: Anesthesia
Earl R. Miller, M. D., San Francisco: Radiology
James A. Evans, M. D., Chief of Vascular Section, Department of Internal Medicine, Lahey Clinic, Boston: Drug Therapy of Hypertension

FOURTH GENERAL SCIENTIFIC ASSEMBLY

Juneau Hall—Milwaukee Auditorium

Chairman: M. G. Rice, M. D., Stevens Point

2:30 p. m.: ENDOMETRIOSIS: Richard TeLinde, M. D., Baltimore

Round Table Discussions

1:00–2:00 p. m.: Auditorium

South Kilbourn Hall: **THE ROLE OF REGIONAL ANESTHESIA IN SURGERY, OBSTETRICS, DIAGNOSIS AND THERAPY:**

Chairman: Sidney Orth, M. D., Madison
Panel: **John J. Bonica, M. D.**, Tacoma, Washington
George S. Kilkenny, M. D., Associate Clinical Professor of Obstetrics and Gynecology, Marquette University School of Medicine, Milwaukee
Robert M. Wylde, M. D., Madison
Anthony Tella, M. D., Clinical Instructor in Anesthesiology, Marquette University School of Medicine, Milwaukee

Rear of Juneau Hall: **INCONTINENCE OF URINE IN WOMEN: Richard TeLinde, M. D.**, Baltimore
Chairman: Frederick J. Hofmeister, M. D., Milwaukee

Room 3, Sports Arena: **NEWER DRUGS AND THEIR USES: Ovid O. Meyer, M. D.**, Madison

SCIENTIFIC SESSIONS

Wednesday, May 4

3:00–3:30 p. m.: EMERGENCIES IN THE NEWBORN PERIOD: Lee Forrest Hill, M. D., Des Moines, Iowa

3:30–4:15 p. m.: RECESS TO VIEW EXHIBITS

4:15–4:45 p. m.: THE DIAGNOSIS AND TREATMENT OF LIGAMENT INJURIES TO THE KNEE: Don H. O'Donoghue, M. D., Oklahoma City

4:45–5:15 p. m.: MODERN MANAGEMENT OF THE HYPERTENSIVE PATIENT: James A. Evans, M. D., Boston

SPECIAL PROGRAM ON ANESTHESIOLOGY

South Kilbourn Hall—Milwaukee Auditorium

Chairman: Wilson S. Phillips, M. D., Milwaukee

2:15–3:00 p. m.: THE PROPER ROLE OF THE ANESTHESIOLOGIST IN THE MANAGEMENT OF PAIN: John J. Bonica, M. D., Tacoma, Washington

3:00–3:30 p. m.: SURGICAL AND ANESTHESIA PROBLEMS ARISING FROM THE CLINICAL USE OF CORTISONE: Sherwood W. Gorens, M. D., Department of Anesthesiology, VA Hospital, Wood

3:30–4:00 p. m.: RECESS TO VIEW EXHIBITS

4:00–4:30 p. m.: IDEAL ANESTHESIA AS VIEWED BY THE THORACIC SURGEON: Benjamin G. Narodick, M. D., Clinical Instructor in Surgery, Marquette University School of Medicine, and Consultant in Thoracic Surgery, VA Hospital, Waukesha

4:30–5:00 p. m.: PROBLEMS OF PEDIATRIC ANESTHESIA: George C. Kreuter, M. D., Chief, Anesthesia Service, Milwaukee Children's Hospital

Round Table Discussions

1:00–2:00 p. m.: Auditorium

North Kilbourn Hall: SUDDEN ILLNESSES IN CHILDREN: Lee Forrest Hill, M. D., Des Moines
Chairman: John C. Peterson, M. D., Milwaukee

Walker Hall: THE PLACE OF RADIOIODINE IN MEDICINE: Earl R. Miller, M. D., San Francisco
Chairman: Hans W. Hefke, M. D., Milwaukee

Room 1, Sports Arena: THE EARLY TREATMENT OF INJURIES TO ATHLETES: Don H. O'Donoghue, M. D., Oklahoma City
Chairman: Albert C. Schmidt, M. D., Milwaukee

Room 4, Sports Arena: CURRENT CONCEPTS IN THE TREATMENT OF PULMONARY LESIONS: Ivan Baronofsky, M. D., Minneapolis
Chairman: Joseph W. Gale, M. D., Madison

Room 2, Sports Arena: THE CHOICE OF HYPERTENSIVE PATIENTS FOR SYMPATHECTOMY: James A. Evans, M. D., Boston
Chairman: Charles W. Crumpton, M. D., Madison

■ DON H. O'DONOGHUE, M. D.

■ BRUCE FRALICK, M. D.

Speaker on Thursday before Section on Ophthalmology and Otolaryngology.

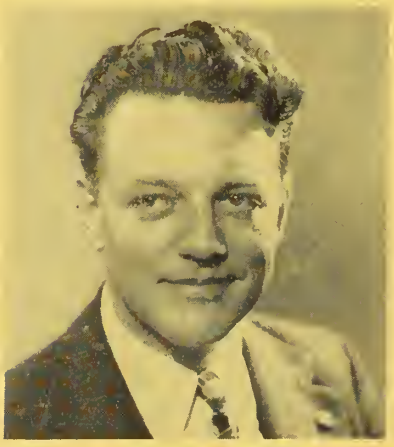
Second Guest Speaker

■ BEN H. SENTURIA, M. D.
St. Louis

SCIENTIFIC SESSIONS

JOSEPH G. BENTON, M. D.

WM. F. GEITTMANN, M. D.



CHARLES P. LARSON, M. D.

Thursday, May 5

FIFTH GENERAL SCIENTIFIC ASSEMBLY

Juneau Hall—Milwaukee Auditorium

Chairman: S. A. Morton, M. D., Milwaukee

9:00–10:00 a. m.: PAIN IN THE NECK
Moderator: **Samuel S. Sorkin, M. D.**, Evansville
Participants:
Lester W. Paul, M. D., Madison: Radiology; **Hans H. Reese, M. D.**, Madison: Neurology; and **Walter P. Blount, M. D.**, Milwaukee: Orthopedics

10:00 a. m.: RECESS TO VIEW EXHIBITS

10:45–11:15 a. m.: PRESENT THERAPY OF BENIGN AND MALIGNANT BREAST CONDITIONS: Herbert Lee, M. D., Professor of Clinical Surgery, Medical College of Virginia, Richmond
(Lecture sponsored by Wisconsin Division, American Cancer Society)

11:15–11:45 a. m.: REHABILITATION OF THE PATIENT WITH CARDIOVASCULAR DISEASE: Joseph G. Benton, M. D., Associate Professor of Physical Medicine and Rehabilitation, New York University College of Medicine, New York City
(The Lucy Ann Droessel Memorial Lecture, Wisconsin Heart Association)

Round Table Discussions

1:00–2:00 p. m.: Auditorium

Rear of Juneau Hall: **CHRONIC RELAPSING PANCREATITIS: Herbert Lee, M. D.**, Richmond, Virginia
Chairman: Kenneth E. Lemmer, M. D., Madison

South Kilbourn Hall: **THE SURGICAL TREATMENT OF ANEURYSMS AND OBSTRUCTIVE LESIONS OF THE AORTA AND PERIPHERAL ARTERIES: Harris B. Shumacker, Jr., M. D.**, Indianapolis
Chairman: Paul F. Hausmann, M. D., Milwaukee

North Kilbourn Hall: **CAN CARDIAC PATIENTS WORK? (Panel Discussion)**
Chairman: Howard L. Correll, M. D., Milwaukee
Participants: **Joseph G. Benton, M. D.**, New York City; **Doctors George A. Hellmuth** and **Lamont R. Schweiger**, Milwaukee

Walker Hall: **AIR EMBOLISM: Charles P. Larson, M. D.**, Tacoma, Washington
Chairman: Dann B. Claudon, M. D., Milwaukee

Room 1, Sports Arena: **THE MANAGEMENT OF ABORTION: William F. Geittmann, M. D.**, Chicago
Chairman: Benjamin E. Urdan, M. D., Milwaukee

Room, 2, Sports Arena: **PROBLEMS AND ADVANCES IN THE TREATMENT OF DIABETES: Bruno J. Peters, M. D.**, Assistant Clinical Professor of Medicine, Marquette University School of Medicine, Milwaukee

SCIENTIFIC SESSIONS

Thursday, May 5

FINAL CLOSING GENERAL SESSION

Juneau Hall—Milwaukee Auditorium

Moderator: K. E. Lemmer, M. D., Madison

2:30–3:00 p. m.: WHAT DOES SURGERY OFFER THE CARDIAC PATIENT?: Harris B. Shumacker, M. D., Professor and Chairman, Department of Surgery, Indiana University School of Medicine, Indianapolis

3:00–3:30 p. m.: SHOULDER PRESENTATION: William F. Geittmann, M. D., Assistant Professor of Obstetrics and Gynecology, Northwestern University Medical School, Chicago

3:30–4:00 p. m.: INVESTIGATION OF THE UNKNOWN DEAD: Charles P. Larson, M. D., Assistant Clinical Professor of Pathology, University of Washington Medical School, Seattle

4:00 p. m.: TEN-MINUTE RECESS

4:10–5:00 p. m.: FIRE AND EXPLOSION HAZARDS IN HOSPITALS, AND THEIR CONTROL: George J. Thomas, M. D., Associate Professor of Surgery and Chairman of the Section on Anesthesiology, University of Pittsburgh School of Medicine

(For this concluding feature of the program, invitations will be extended to hospital superintendents, key nursing personnel, nurse anesthetists, insurance representatives, etc.)

■ HERBERT LEE, M. D.

■ HARRIS B. SHUMACKER, JR., M. D.

■ GEORGE J. THOMAS, M. D.

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EENT Luncheon and Program

12:15 p. m.: Section on Ophthalmology and Otolaryngology: East Room, Hotel Schroeder

1:00 p. m.: Business Meeting

SCIENTIFIC PROGRAM

Chairman: H. G. Schmidt, M. D., Milwaukee

2:00 p. m.: THE COMMON COLD AND ITS TREATMENT: Ralph P. Sproule, M. D., Milwaukee

2:30 p. m.: MINOR OPHTHALMIC SURGERY: F. Bruce Fralick, M. D., Professor and Chairman, Department of Ophthalmology, University of Michigan Medical School, Ann Arbor, Michigan

3:30 p. m.: THE TREATMENT OF EXTERNAL OTITIS: Ben H. Senturia, M. D., Associate Professor of Otology, Washington University School of Medicine, St. Louis, Missouri

4:15 p. m.: THE USE OF MIOTICS IN THE TREATMENT OF STRABISMUS: Samuel S. Blankstein, M. D., Clinical Instructor in Ophthalmology, Marquette University School of Medicine, Milwaukee

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Annual Dinner Features

"THERE *IS* A DOCTOR IN THE HOUSE": The Fond du Lac County Medical Society Auxiliary will present a humorous skit as a part of the program. Participants: Back row, left to right—Mrs. J. F. Coyne, Mrs. W. G. Kendell, Mrs. Howard Mauthe, Dr. F. J. Cerny, Mrs. F. J. Cerny. Front row, left to right—Mrs. N. O. Becker, Mrs. J. S. Huebner, Mrs. H. J. Kief, Mrs. W. E. Myers. Participants not included in the picture: Mrs. James Haberman, Mrs. D. D. Willson, Mrs. R. L. Fransway, Mrs. James McCullough, Mrs. H. J. McLane, Mrs. P. M. Arneson, and Mrs. David Smith.

HOTEL SCHROEDER, THURSDAY, MAY 5—$6.00 PER PLATE

SHORT FORMAL PROGRAM: Short talks by President Arthur J. McCarey and incoming president E. L. Bernhart.

HONORS TO NEW MEMBERS OF "50 YEAR CLUB": The following members will be granted certificates and pins as newly qualified members of the "50 Year Club":

OTTO F. DIERKER, M. D. ..... Watertown
EDW. S. ELLIOTT, M. D. ..... Fox Lake
CHARLES H. FEASLER, M. D. ..... Oconomowoc
GEORGE E. FORKIN, M. D. ..... Menasha
LEOPOLD J. FRIEND, M. D. ..... Beloit
JOSEPH J. GRAMLING, Sr., M. D. ..... Milwaukee
FRANK H. KELLEY, M. D. ..... Merrill
OSCAR KNUTSON, M. D. ..... Osseo
FREDERICK K. KOLB, M. D. ..... Sheboygan
WILLIAM T. LINDSAY, M. D. ..... Madison
JOSEPH W. LIVINGSTONE, M. D. ..... Hudson
HOMER D. LUDDEN, M. D. ..... Mineral Point
WILLIAM LUMSDEN, M. D. ..... Menomonie
HARRY H. MEUSEL, M. D. ..... Oshkosh
ENOCH F. PETERSON, M. D. ..... Milwaukee
JAMES J. ROBB, M. D. ..... Green Bay
CHARLES A. SQUIRE, M. D. ..... Sheboygan
WM. J. WALDSCHMIDT, M. D. ..... Fond du Lac
SIDNEY H. WETZLER, M. D. ..... Milwaukee
ARTHUR G. WILCOX, M. D. ..... Solon Springs

FLOOR SHOW: In addition to the skit of the Fond du Lac County Medical Society Auxiliary, there will be a professional floor show. The program will conclude at 10:00 p. m.

MAKE YOUR RESERVATIONS EARLY . . . ONLY 450 CAN BE ACCOMMODATED

SCIENTIFIC EXHIBITS

Reflect Varied and Significant Research of Wisconsin Physicians and Medical Groups

The scientific exhibits listed below have been selected for the 1955 Annual Meeting by L. G. Kindschi, M.D., Monroe, a member of the Council on Scientific Work. The exhibits will be located in Bruce Hall of the Milwaukee Auditorium.

Provision has been made on the time schedule so that these fine exhibits can be studied in the early morning hours before the formal scientific meetings and at the close of the morning sessions before lunch, as well as during a special recess period in the afternoon. The Council on Scientific Work appreciates the effort which went into the preparation of these exhibits and recommends that all physicians attending the Annual Meeting study their content and discuss the material with those in attendance.

S-7a—TUMORS AND DISEASES OF THE SALIVARY GLANDS

R. P. Gingrass, M. D., D. D. S., Milwaukee

The exhibit will consist of Kodachrome transparencies demonstrating benign and malignant tumors of the salivary glands, cysts ranulae, sialolithiasis, Mikulicz's disease, tumors arising from aberrant salivary gland tissue in lips, palate, tongue, etc. Incisions for exposure of parotid tumors, preserving the facial nerve, salivary fistulas, etc., will be shown.

S-8, 9—ELECTROCARDIOGRAPHIC PITFALLS

R. H. Wasserburger, M. D., and T. H. Lorenz, M. D., Veterans Administration Hospital and University Hospitals, Madison

Information given includes data on a large series of Negro and Caucasian patients who, although exhibiting normal QRS complexes, showed persistent and marked RST and T wave abnormalities in the precordial leads. The mode of production of these abnormalities through brief hyperventilation is shown in serial electrocardiographic tracings; ameliorating effects of reassurance, potassium salts, and intravenous Pro-Banthine are shown. Pertinent clinical summaries are also included.

S-10, 11—TRIGEMINAL NEURALGIA

H. M. Suckle, M. D., Madison

The exhibit will depict the diagnosis, the pathology, and the medical and surgical treatments of trigeminal neuralgia. The medical treatments will include the latest forms of injection therapy. Advancements in surgical treatment that have been used in the past several years, including section of the nerve and decompression of the gasserian ganglion, will also be shown.

S-12, 13—FACIAL FRACTURES

F. D. Bernard, D. D. S., M. D., Madison, and the University of Wisconsin Medical School

The exhibit will cover the matter of diagnosis and treatment, and there will be illustrative material in the form of colored photographs.

S-14a—ADENOMAS OF THE COLON AND RECTUM

Robert Turell, M. D., Albert Einstein Medical School, New York City

This exhibit deals with the incidence, distribution, types, genesis, familial tendency, cancer potential, and treatment of discrete, single or multiple scattered adenomas. Practically all of these items are illustrated by means of black and white and colored gross and/or microscopic transparencies. The text is precise, clear, and short. The major portion of the exhibit is devoted to treatment and illustrates the newest electrothermic methods and surgical technics.

S-14, 15—SURGICAL TREATMENT OF VARICOSE VEINS BY STRIPPING TECHNIC

T. T. Myers, M. D., K. A. Lofgren, M. D., and L. R. Smith, M. D, Mayo Clinic, Rochester, Minnesota

Varicose veins of the lower extremity are progressive, recurring, and disabling. They have not responded satisfactorily to minor surgery and injection therapy. The most satisfactory long-term control has been accomplished by major surgery which consists of extensive removal of the veins by stripping and direct dissection.

The exhibit consists of (1) models, diagrams, and photographs explaining the technic of stripping the long saphenous and the short saphenous veins; (2) illustrations of the important venous patterns from a surgical

standpoint; (3) simplified diagnostic tests and venous pressure studies before and after surgery; and (4) graphs showing the results of partial stripping and complete stripping performed on 1,189 lower extremities.

S-16, 17—PRIMARY TUMORS OF THE SOFT TISSUES OF THE EXTREMITIES, EXCLUSIVE OF EPITHELIAL TUMORS (An Analysis of 500 Consecutive Cases)

E. H. Soule, M. D., R. K. Ghormley, M. D., H. H. Young, M. D., M. B. Coventry, M. D., P. R. Lipscomb, M. D., P. M. Janes, M. D., J. C. Ivins, M. D., E. D. Henderson, M. D., W. H. Bickel, M. D., and E. W. Johnson, Jr., M. D., Mayo Clinic, Rochester, Minnesota

This exhibit is based on our experience with soft tissue tumors of the extremities (exclusive of epithelial tumors), with emphasis on gross and microscopic appearance of these tumors. Six major groups to be shown are: (1) fibromatous tumors; (2) myomatous tumors; (3) lipomatous tumors; (4) neuromatous tumors; (5) angiomatous tumors; and (6) miscellaneous tumors.

A benign tumor and its malignant counterpart will be demonstrated whenever practicable. The diagnosis of such tumors hinges upon biopsy studies of the presenting mass, and definitive treatment of the lesion must be based on these findings.

S-18—CANCER PROBLEMS IN INFANCY AND CHILDHOOD

H. A. Waisman, M. D., Department of Pediatrics, University of Wisconsin Medical School

The material is presented in the form of Kodachrome illustrations of tumors and some examples of histological variations of neoplasms as they occur in infancy and childhood. Results of therapy are explained.

S-19—COMPARISON OF MORBIDITY AND MORTALITY-TUBERCULOSIS, CANCER, AND CARDIAC DISEASE—BY SEX AND AGE

Wisconsin Anti-Tuberculosis Association

The highest morbidity and mortality from pulmonary tuberculosis, cancer of the bronchi and lungs, and cardiac disease occurs in the middle and older age groups, particularly among males. In this exhibit, these facts will be graphically portrayed by means of x-ray illustrations.

Early evidence of pathology may often be found on routine hospital admission x-ray films in patients hospitalized for other reasons.

S-20, 21—RESEARCH AND TEACHING AT COLUMBIA HOSPITAL

The exhibit shows various phases of the diagnostic, therapeutic, and teaching activities carried on by the staff of Columbia Hospital, Milwaukee.

S-22—E.E.G. IN DIAGNOSIS OF NEUROLOGICAL DISORDERS

F. J. Millen, M. D., and M. J. Primakow, M. D., Marquette University School of Medicine and VA Hospital, Wood

This exhibit shows the use and value of E.E.G.'s in the diagnosis of common neurological disorders. It consists of clinical cases, histories, and typical electroencephalographic findings. Sample E.E.G.'s will be demonstrated, and an electroencephalograph machine may be present in the booth for a demonstration.

S-23—ISOLATED SURVIVING HEART

Department of Pharmacology, Marquette University, and the Wisconsin Heart Association

The Craver–Anderson apparatus for perfusing the surviving isolated mammalian heart will be shown with a rabbit heart in operation. The effect of drugs upon coronary flow, heart rate, and amplitude of contraction are studied with this preparation.

S-24, 25—DERMATOLOGIC LESIONS IN GENERAL PRACTICE

R. J. Rowe, M. D., and H. C. Dangle, M. D., Marshfield Clinic, Marshfield

The exhibit consists of 40 enlarged Kodachrome pictures of malignant and nonmalignant lesions seen on the skin. There are accompanying legends giving a brief description of the clinical and pathologic findings and treatment. In addition we have 2 x 2 Kodachrome slides of representative pathologic sections and some 2 x 2 clinical slides for variety. The exhibit is an alteration of the one shown two years ago; additions and substitutions have been made.

S-25a—CANCER OF THE CERVIX

Wisconsin and Milwaukee Divisions, American Cancer Society

The major portion of the exhibit deals with the International Classification of uterine cancer translated into color plates illustrating the clinical picture, biopsy, and vaginal smears in "not normal but malignant" lesions and "not normal but benign" lesions. The problem of cancer of the cervical stump is graphically depicted. Additional material provided in statistical form covers the etiological factors, diagnosis, and treatment of uterine cancer.

S-25b—CONGENITAL ABSENCE OF THE VAGINA AND ITS SURGICAL CORRECTION

E. A. Habeck, M. D., Department of Gynecology and Obstetrics, Deaconess Hospital, Milwaukee

The exhibit will demonstrate the modern surgical correction of this centuries-old female congenital defect. The procedure is today recognized on the European and American continents as the most successful, safe, and feasible method of correction. Moulds and procedures and technic, together with proper aftercare, are demonstrated. Reasons for failure are pointed out, and the necessary requirements for success are emphasized.

S-26, 27—GROSS TISSUE DEMONSTRATIONS

Section on Pathology and the Wisconsin Society of Pathologists

Fixed and fresh gross pathological specimens will be demonstrated by various pathologists.

S-28, 29—CHROMATOGRAPHY AND CLINICAL MEDICINE

Kenneth D. Brown, Ph. D., Department of Biochemistry, Marquette University School of Medicine

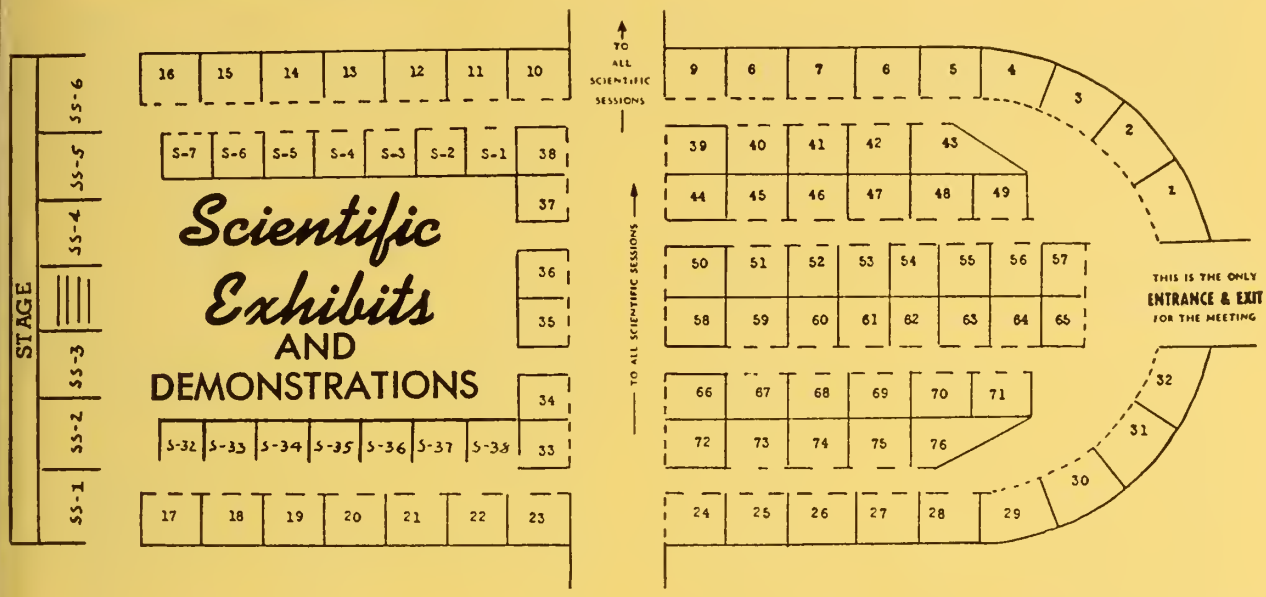
The display will be built around paper electrophoresis. This chromatographic technic has received the greatest acceptance in clinical research. The paper electrophoretic equipment currently in use in the Biochemistry Department of the Medical School will be displayed, along with the various other pieces of equipment necessary for staining, quantitating, etc., of the developed strips. The clinical research applications illustrated will include abnormal hemoglobins, serum proteins (normal and pathological), and atherosclerosis.

Also displayed will be column chromatography and filter paper chromatography. The column chromatography will be illustrated with colored compounds so the visitors will be able to see the separation on the column. Paper chromatography will include the descending method and the ascending method. Previously developed chromatograms, as well as developing chromatograms, will be displayed. The systems illustrated will be the carbohydrates and the amino acids.

S-30, 31—HAZARDS OF SOLVENTS: AT HOME AND ON THE JOB

Council on Industrial Health of the American Medical Association

By use of photographs, charts, and explanatory materials, this exhibit outlines general principles of hazards commonly encountered and gives special emphasis to solvent vapors and effects of carbon tetrachloride.



THE TECHNICAL EXHIBITS

Without the support of the firms listed on the following pages, we could not afford an Annual Meeting without a registration fee of $10 or more. To what extent these organizations will continue to support our meeting is dependent upon the interest shown by physicians in attendance.

It will be appreciated if you will make a special effort to visit the exhibits during the intermission periods provided and to *register* at booths with products of special interest to you. This evidence of interest will provide us with funds so that outstanding speakers can be secured for future programs.

Your cooperation will be appreciated.

Booth — Company and Products

37—Abbott Laboratories, North Chicago, Ill.

Our exhibit will feature *Blutene*(R) Chloride (tolonium chloride, Abbott), an orally administered nonhormonal agent for treatment and prevention of functional uterine bleeding (monometrorrhagia). *Blutene's* chemical structure is totally unrelated to estrogens. Symptoms usually are relieved with only one 100-mg. tablet taken with meals at time of bleeding. One course of treatment usually controls symptoms; but, in long-standing cases of abnormal uterine bleeding, treatment may extend over two or three menstrual periods.

73—American Hospital Supply Corporation, Evanston, Ill.

68—Ames Company, Inc., Elkhart, Ind.

Clinitest, for urine-sugar analysis, is standardized. This assures uniformly reliable results whenever and wherever a test is performed—office, ward, clinic, or patient's home.

Ictotest, a new, specific, and sensitive Ames diagnostic tablet test for detection of urine bilirubin for aid in the diagnosis and management of jaundice and hepatitis, will be on display.

66—Ayerst Laboratories, New York

You are cordially invited to visit our booth where representatives will be on hand to discuss *Premarin*, *Antabuse*, and *Trilene*, as well as other products of our manufacture.

Booth — Company and Products

75—Baby Development Clinic, Chicago

Maternity Counselling Service offers products and literature helpful in teaching expectant mothers (and fathers) the physical and emotional aspects of parent-child relationship arising out of daily care in feeding, bathing, sleeping, and toileting. We also have aids for parents in understanding and providing emotional security for children through the school ages.

55—The Baker Laboratories, Inc., Cleveland

Baker's Modified Milk and *Varamel*, two successful products for infant feeding, will be on display. Baker representatives will be glad to discuss the practical application of Grade A milk, adjusted fat composition, zero curd tension, synthetic vitamins, and other important factors which help to eliminate many of the problems in modern infant feeding.

32—Barr X-Ray Company, Inc., Milwaukee

The welcome mat again will be out at our usual place, first booth to the left as you enter the exhibit hall. If you have any x-ray problems to discuss or if you want to "just talk," stop and visit with us.

74—Beech-Nut Packing Company, New York

The average American is using more and more "convenience" foods in his diet. Stop at our booth for information about some new ideas for the use of Strained and Junior Foods in adult diets.

Booth **Company and Products**

45—Benson Optical Company, Minneapolis

We will show all that is new in the ophthalmic line—FRAMES from all leading manufacturers, custom made and imports; LENSES, the new all plastic Armorlite lens and Multifocals that are as new as 1955; INSTRUMENTS AND EQUIPMENT to fill your needs for a complete and modern office.

S-7—House of Bidwell, Inc., Milwaukee

On display will be an exhibit of the various types of artificial limbs, the Jewett Hyperextension Brace, and various other types of prosthetic, orthopedic, and surgical appliances.

67—Bilhuber-Knoll Corporation, Orange, N. J.

Metrazol has been the subject of intensive investigation in the past year. Information concerning the advantages of *Metrazol* as a vasomotor and respiratory stimulant, as well as a tonic, will be available. Your discussion of other Bilhuber products, such as *Dilaudid, Theocalcin,* and *Bromural,* is also invited.

38—The Borden Company, Prescription Products Division, New York

There's no better place to talk over the latest information on infant feeding than the Borden Prescription Products booth. On display is the complete line of Borden's infant formula products for every feeding purpose or preference. You can feed almost any baby *Bremil, Mull-Soy (Liquid or Powdered), Dryco,* or *Biolac.*

S-6—Brook Hill Farms, Genesee Depot, Wis.

Samples of all Brook Hill dietary milks will be served. These include *Certified Enzylac, Certified Fat Free Enzylac, Bac-T* (a sweet-skimmed acidophilus milk), *Kazol-Acidophilus,* and *Dari-Vi* (homogenized-vitamins). Brook Hill Farms products are distributed by all dairies in the Milwaukee and Chicago metropolitan areas.

46—Brooks Appliance Company, Chicago

We will exhibit and describe in detail the technic of applying the combination pressure bandages. The moist medicated *Primer Bandage* and the *Dalzoflex Elastic Adhesive Bandage,* which are used in treating leg ulcers and phlebitis, will be shown. Elastic stockings, the *Nulast Elastic Crepe Bandages,* and surgical instruments will also be displayed.

39—Burroughs Wellcome & Co., Inc., Tuckahoe, N. Y.

New Wellcome(R) brand solution of *Digoxin* for Injection—No dilution required. For intramuscular or intravenous use. *Digoxin* 'B.W. & Co.' is also available in tablets for oral digitalization.

Neosporin(R) brand Polymyxin B—Bacitracin—Neomycin.

Antibiotic Ointment—For treatment of topical bacterial infections with minimal risk of sensitization.

Marezine(R) Hydrochloride brand Cyclizine Hydrochloride, Oral—For prevention and treatment of nausea and vomiting of pregnancy, motion sickness, and vertigo. Also available for injection in postoperative vomiting.

71—Carnation Company, Los Angeles

We are pleased to present the first *Instant* Nonfat Dry Milk. You are invited to sample this miracle product—the greatest advance in the dairy industry since homogenization. You'll like its fresh milk flavor; it dissolves instantly, even in ice water. An excellent, economical source of protein; useful in diets for weight reduction, high protein, undernutrition, pregnancy, and geriatrics.

58—Ciba Pharmaceutical Products, Inc., Summit, N. J.

Our exhibit will feature *Serpasil,* a pure crystalline alkaloid of Rauwolfia possessing the essential antihypertensive actions of the whole root. *Serpasil* offers mild, gradual, sustained lowering of blood pressure with a slowing of the heart rate: a tranquilizing effect beneficial in most cases of hypertension; and unvarying potency.

Booth **Company and Products**

SS-3—Cameron Surgical Specialty Company, Chicago

See the Cameron electro-surgical units, also new biopsy punch combining coagulation; electro-diagnostic lamp and instrument outfits; omniangle gastroscope; Boros flexible esophagoscope; Coagulair and Dualite sigmoidoscopes; Tele-Vaginalite; Mirrolite and other headlites; retractors and many other instruments for general and special diagnosis, treatment, and surgery.

SS-2—Coca Cola Bottling Company, Milwaukee

S-37—Dictaphone Corporation, New York

For busy doctors, our exhibit features the new Dictaphone Time-Master dictating machine with power control (all dictating controls on the hand microphone). For hospitals, Dictaphone presents the Telecord System of network dictation by phone for complete, accurate medical records.

18—Doerflinger Artificial Limb Company, Milwaukee

We invite you to visit our display of prosthetic, orthopedic, and surgical appliances. Featured will be the "Otto Bock Controlled Knee Joint" for above-the-knee amputations.

S-1—Eaton Laboratories, Inc., Norwich, N. Y.

For prompt results in urinary tract infections, *Furadantin*(R) is now available in the form of tablets and as *Furadantin Oral Suspension.* Within 30 minutes after this drug is ingested, the urine becomes strongly antibacterial.

The latest dosage forms of the topical antibacterial agent *Furacin*(R) include *Furacin Soluble Powder* for painless application to wounds and burns and *Furacin Urethral Suppositories* for bacterial urethritis.

For cutaneous fungal infections, *Furaspor*(R) *Cream* is rapidly effective and pleasant to use.

17—Encyclopedia Americana, Grand Rapids

We will display the 1955 edition of the *Encyclopedia Americana* and the *Book of Knowledge.* Both are keyed to our American educational system and are included in one offer. Members and guests are invited to register for a free, 48-page Hammond Atlas which is printed in color.

15—Encyclopedia Britannica, Chicago

S-3—Endo Products, Inc., Chicago

We invite your interest in *Percodan,* effective, prompt-acting analgesic; *Cumertilin Tablets,* new concept in mercurial diuretics; and *Hycodan Bitartrate Tablets and Syrup,* the original Council-accepted Dihydrocodienone, for cough relief. Our representatives will discuss in detail these and other products of our manufacture.

SS-1—Evron Company, Chicago

Pentritol Tempules, pentaerythritol tetranitrate in a capsule of controlled disintegration, is presented by The Evron Company for effective treatment of the anginal syndrome. This is an original form of medication by Evron allowing 12 hours of sustained vasodilation with the administration of one *Tempule.* The drug is recommended for cases where coronary vasodilation, via the oral route, is indicated. Many of the 60 Evron products accepted by the Council on Pharmacy and Chemistry of the American Medical Association will also be displayed.

8—H. G. Fischer & Company, Franklin Park, Ill.

Latest models of modern x-ray, and F.C.C.-approved physical medicine and rehabilitation equipment, all of highest quality materials and construction will be on display. Our representatives will give demonstrations and quote today's low prices.

Booth Company and Products

72—C. B. Fleet Company, Inc., Lynchburg, Va.

During the past 50 years *Phospho-Soda* (Fleet) has been a symbol of elegance in sodium phosphate medication. *Fleet Enema Disposable Unit*, an enema solution of *Phospho-Soda* (Fleet), is a worthy companion product. The single-use unit simplifies and assures satisfying preparation for proctoscopy, and for a routine enema it is a boon to the hospitalized patient.

54—Geigy Pharmaceuticals, Division of Geigy Chemical Corp., New York

Geigy will feature Council-accepted *Butazolidin*(R), oral nonhormonal antiarthritic, and *Medomin*(R), new hypnotic-sedative affording sound, refreshing sleep and alert awakening without hang-over. Also on display will be *Eurax*(R) Cream and Lotion, antipruritic and scabicide; *Tromexan*(R), oral anticoagulant of rapid action, little cumulation, and diminished risk of sustained or severe hemorrhage; and *Sterosan*(R) Cream and Ointment, bacteriostatic and fungistatic for treatment of pyogenic and mycotic skin disorders.

1—General Electric Company, X-Ray Department, Milwaukee

We will feature the General Electric Cardioscribe, direct writing cardiograph, and the Model "F" Inductotherm, diatherm unit. The Cardioscribe's swing-out paper drive, advance-design cabinet, and exclusive chest-lead selector switch make this unit particularly noteworthy. Both the Cardioscribe and Inductotherm will be demonstrated on request.

40—Gerber Products Company, Fremont, Mich.

When milk is contraindicated as the basic food for infants, Gerber's "Meat Base Formula" can provide a nutritionally adequate replacement. It is well accepted and tolerated by infants of all ages. We invite you to evaluate "Meat Base Formula" and the complete line of supplementary baby foods. You are also invited to review new editions of Gerber's baby care and adult special diet booklets. Each is designed especially for distribution by physicians. Each provides non-controversial information in simple, easy-to-understand language. The service is complimentary.

S-4—H. J. Heinz Company, Pittsburgh

Heinz Strained Meats—first in glass jars—have been readily accepted by the medical profession and mothers alike. Now, Junior Meats have been added and the Heinz line of baby foods totals over 60 varieties. Babies, young children, and those elderly folks requiring soft diets may have a wide selection from the very nourishing foods. We will have literature available for physicians and patients.

70—Hoffmann-La Roche, Inc., Nutley, N. J.

Noludar is a new, non-barbiturate hypnotic which provides effective relief of insomnia and tension states. *Noludar* is so well tolerated that side effects such as nausea, vomiting, and dizziness are rarely, if ever, experienced with therapeutic doses. *Noludar* is available in scored tablets of two strengths, 50 mg. and 200 mg., and in a cordial-flavored elixir, 50 mg. per teaspoonful.

S-38—Horlicks Corporation, Pharmaceutical Division, Racine

We will present *Nulacin*—a unique milk-antacid tablet formulated to dissolve slowly in the mouth. Thus, the contained antacids are gradually released, providing the ambulatory patient with continuous acid neutralization. Because of this new mode of treatment, *Nulacin* is comparable in efficacy to the continuous intragastric drip method.

33, 34—Hurley X-Ray Company, Milwaukee

We will exhibit items of interest in the Burdick Physical Medicine and Picker X-Ray lines of equipment and accessories. Stop by to look at these lines and have a visit with our fieldmen.

Booth Company and Products

29, 30—Karrer Company, Milwaukee

We invite you to visit our display of instruments, drugs, and equipment. Karrer Company representatives especially trained to understand professional needs will be on hand to discuss products with you.

61—Kellogg Company, Battle Creek, Mich.

We will introduce Kellogg's *Special K*, an entirely new, ready-to-eat, high-protein cereal food. This product, which contains more protein than any other leading cereal —hot or cold—and twice as much as their average, has, in addition, remarkable vitamin and mineral values. Our representatives will be happy to answer questions about *Special K*.

4—Kremers-Urban Company, Milwaukee

Descriptive literature and specimen material will be available on *Phyatromine-H* and *Salimeph-C*, the inject-oral combination for relief of crippling skeletal muscle spasm; *Hepteryl-12* and *Ronuvin*, the inject-oral combination for fast and sustained complete hematinic response; *Nitrol* Ointment for sustained vasodilatation in angina; and *Kutapressin* and *Kused*.

28—Lakeside Laboratories, Inc., Milwaukee

You are cordially invited to visit the Lakeside booth where our sales representatives will be available to discuss the oral diuretic *Neohydrin;* our visceral eutonic *Dactil;* and the newest piperidol, *Piptal*.

64—Langer Laboratories, Inc., Milwaukee

Herman and Jack greet you once more
With drugs both old and new
And hope that you will stop to chat
We like to talk to you.

69—Lederle Laboratories Division, American Cyanamid Company, Pearl River, N. Y.

You are cordially invited to visit our exhibit where you will find our representative prepared to give you the latest information on Lederle products.

44—Eli Lilly and Company, Indianapolis

You are cordially invited to visit the Lilly exhibit. The display will contain information on recent therapeutic developments. Lilly sales people will be in attendance. They welcome your questions about Lilly products.

42—J. B. Lippincott Company, Philadelphia

We will present, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

SS-4—Loewi and Company, Milwaukee

Our booth will be designed to give up-to-the-minute market information plus information on thousands of corporations whose stock is publicly held. A Dow-Jones News Wire will be installed, and a private line will be available to our Milwaukee office for quotations on any securities.

S-33—P. Lorillard Company, New York

P. Lorillard Company, manufacturers of OLD GOLD Cigarettes as well as BRIGGS Pipe Mixture and other famous tobacco products, will exhibit and demonstrate their KENT Cigarettes with the exclusive Micronite Filter.

35—M & R Laboratories, Columbus, Ohio

Your *Similac* representatives are pleased to have the opportunity to discuss with you the role of *Similac* in infant feeding. They have for you the latest Pediatric Research Conference Reports and current reprints of pediatric nutritional interest.

Booth Company and Products

3—Maico Hearing Service of Madison, Madison, Wis.

The display sponsored by Maico Hearing Service of Madison and Milwaukee will include a full line of hearing test equipment, hearing aids, and Maico's new electronic stethescope, the Stethetron. Audiometric screening tests will be given to doctors visiting the display.

22—Massachusetts Indemnity Insurance Company, Milwaukee

The Massachusetts Indemnity Insurance Company will have booth 22 for the convenience of its policyholders and to supply information to any of the doctors or their associates. We issue only non-cancellable, guaranteed renewable to age 65, and incontestable disability insurance, providing income for life resulting from accident, and for up to 10 years for sickness claims. Benefits are payable if you are unable to follow your own occupation during the first five years of any claim.

59—The S. E. Massengill Company, Bristol, Tenn.

We will feature *Salcort*, the new antiarthritic with multiple advantages. Salicylates and cortisone are complementary when combined . . . much lower dosage is required . . . side effects are minimized. There are no withdrawal problems with *Salcort*.

26—Mead Johnson & Company, Evansville, Ind.

We invite you to see new displays of *Liquid Lactum* and *Powdered Lactum*, the infant formula products with balanced caloric distribution. Also featured will be *Liquid Sobee*, a hypoallergenic (milk-free) soya formula; *Natalins*, the smaller prenatal vitamin-mineral capsules; *Natalins-T*, for the treatment of anemias of pregnancy plus protective nutritional support; and *Sustagen*, the complete food for tube or oral feeding.

76—Medical Electric Company, Milwaukee

6—The Medical Protective Company, Fort Wayne, Ind.

An unparalleled record of successful malpractice protection since 1899 distinguishes The Medical Protective Company from all others. Year in and year out 99.94 per cent of its policyholders have been completely covered under $2,500. It's a sustained record that causes Medical Protective to be considered the doctor's most secure source of security.

23—Medico-Mart, Inc., Milwaukee

Our display will consist of Hamilton equipment, Raytheon Microtherms, Castle and American sterilizers, surgical instruments, and Council-accepted pharmaceuticals.

65—The Wm. S. Merrell Company, Cincinnati, Ohio

TACE, the unique non-steroid developed by Merrell, offers a new approach to the treatment of the menopause. *TACE* is temporarily stored in body fat, and released over an extended period of time. One course of *TACE* therapy is generally all that is required to ease many patients into the symptom-free postmenopausal period. Symptom relief is excellent, and side effects are virtually absent. Merrell representatives will answer any questions you have concerning this new and distinctive estrogen as well as discuss other Merrell specialties.

13—Midwest Medical Equipment Co., Minneapolis

S-34—Miles Reproducer Company, New York

We will show the Walkie-Recordall—world's only recorder of its kind. It is battery and/or AC operated and has a total weight of 8 lbs. It will record undetected in or out of a closed briefcase, at a radius of up to 60 feet, for as long as 4 hours. Voice-activated, the self start-stop mechanism eliminates supervision. Permanent records are made for a cost of only three cents per hour.

Booth Company and Products

25—Miller Surgical Company, Chicago

We will feature the Miller *Electro-Scalpel*. This unit cuts, desiccates, fulgurates, coagulates and is used for most delicate work up to light major surgery. Accessories such as Snares and Smoke Ejectors are available. We also have a complete line of diagnostic equipment consisting of Illuminated Otoscopes, Ophthalmoscopes, Eyespud with Magnet, Transillumination Lamps, Headlights, Vaginal Speculum with Smoke Ejector, Gorsch Operating Scopes and Stainless Steel Proctoscopes, (all sizes with magnification), Suction Tubes, and Grasping Forceps.

50—V. Mueller & Company, Chicago

We will display a complete line of surgeon's instruments along with many new items that have been developed during the past year.

20—The National Drug Company, Philadelphia

The featured product will be *Parenzyme Intramuscular* Trypsin, which is a new, effective weapon against acute local inflammation. It restores local circulation with dramatic benefits in phlebitis (thrombophlebitis and phlebothrombosis); ocular inflammation (iritis, iridocyclitis and chorioretinitis); traumatic wounds; and varicose and diabetic leg ulcers. *Parenzyme Intramuscular* Trypsin is based on an entirely new concept of biological continuity . . . in terms of clinical enzymology. In very small doses, it initiates physiologic mechanisms and dramatically restores circulation, expedites repair of tissue, and prevents tissue necrosis.

11—A. R. Nechin Company, Chicago

The *Jones Air Basal*, the newest concept in metabolism testing, will be demonstrated. This unit uses no oxygen tanks or capsules but makes use of the oxygen in the room air. This, plus a unique method of adjusting the volume and time connections, eliminates practically all the irregularities usually found in the older oxygen method.

The *Cardiotron*, direct-recording electrocardiograph, will also be demonstrated.

27—John Nichols, Inc., Milwaukee

The Gray *PhonAudograph* is a remote dictating system tailored to fit the needs of the individual user—at a cost lower than that for separate units at your desk and your secretary's. You have all the advantages of mechanical dictation with none of the mechanics. Those of you who must necessarily use individual machines will be amazed at the new series 5 Gray *Audograph*, which features complete control from the microphone. This equipment can be seen in our Booth 27.

SS-5—Orthopedic Appliance Company, Milwaukee

We will display upper and lower extremity prosthesis, bracing and orthopedic corsets and supports.

12—H. E. Pengelly X-Ray Company, Milwaukee

We will once again be happy to welcome you to our booth and trust you will drop in to see us during your Annual Meeting. On display you will see the latest in X-Ray accessories and Electro-Medical equipment.

48—Pet Milk Company, St. Louis

We will have a variety of time-saving material available to busy physicians. Our representatives will be on hand to discuss the merits of *Pet* Evaporated Milk for infant feeding and Instant *Pet* Nonfat Dry Milk for special diets. A miniature *Pet* Evaporated Milk can will be given to all visitors.

Booth Company and Products

31—Pfizer Laboratories, Brooklyn

Terramycin Intramuscular, Cortril, and *Bonamine* will be the highlights this year of a star-studded cast including the complete line of tested and proved Terramycin dosage forms and *Tetracyn,* the latest broad-spectrum antibiotic. Also shown will be the Steraject line of injectable penicillin and Combiotic preparations.

62, 63—Physicians & Hospitals Supply Company, Inc., Minneapolis

Our representatives will be glad to demonstrate all of the latest equipment, including the newest FCC-approved diathermy, electrocardiographs, modern office furniture, and many other items of interest.

16—Professional Business Service, La Crosse

"Business efficiency experts for the medical office," is the description applied to this service by clients. Representatives will be at the booth to greet doctors and explain the scope of service available.

24—R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL, CAVALIER King Size, or WINSTON, the distinctive new, king-size, filter cigarette.

53—A. H. Robins Company, Inc., Richmond, Va.

Donnatal Extentabs, first of Robins' prescription items available in this newly perfected Extended-Action tablet form, will be featured at our exhibit. Representatives will also welcome the opportunity to discuss the advantages of the other medications incorporating the spasmolytic-sedative efficacy of the *Donnatal* formula.

43—Roemer Drug Company, Milwaukee

We invite you to visit our exhibit of clinical laboratory equipment and supplies.

56—J. B. Roerig and Company, Chicago

We will feature *Roetinic,* the new 1-a-day capsule hematinic for all anemias amenable to oral therapy; *Bonadoxin,* for the prevention of nausea and vomiting of pregnancy and postoperatively; *ASF,* Roerig's new anti-stress formula; and *Vi-Thyro,* for the vitalized thyroid and improved thyroid action. Also available will be *Viterra, Viterra Therapeutic, Amplus, Obron, Obron Hematinic,* and *Heptuna Plus.* Samples and literature may be had on all products.

52—Sandoz Pharmaceuticals, East Hanover, N. J.

Our display will feature:

Cafergot—Available in oral and rectal form for control of head pain in migraine and other vascular headaches.

Methergine—"The best way to treat postpartum hemorrhage is to prevent its occurrence." *Methergine,* qualitatively, quantitatively, and in duration of effect, is a superior oxytocic. The use of *Methergine* is not attended by toxic side effects or undesirable side reactions.

57—W. B. Saunders Company, Philadelphia

John Green will once again be on hand with Saunders' complete line. Among the newest of special interest will be Cecil-Loeb: *Medicine; Current Therapy 1955;* Greenhill: *Obstetrics;* Cantarow & Trumper: *Clinical Biochemistry;* Deutschberger: *Fluoroscopy;* Shackelford: *Bickham's Surgery of the Alimentary Tract;* and a new edition of Christopher: *Minor Surgery.*

Booth Company and Products

9—Schering Corporation, Bloomfield, N. J.

You are cordially invited to visit the Schering exhibit where new therapeutic developments will be featured. Our representatives will be present to welcome you and to discuss with you these products of our manufacture.

10—G. D. Searle & Company, Chicago

Members of our Medical and Medical Service Departments will be on hand to discuss the latest developments in Searle research. Featured will be *Banthine* and *Pro-Banthine,* leaders in anticholinergic therapy; *Dramamine* for the relief of motion sickness and other conditions characterized by nausea; and *Metamucil* for the correction of constipation.

60—Sharp & Dohme, Division of Merck & Company, Philadelphia

Our exhibit will present highlights on steroid therapy featuring *Hydrocortone, Cortone, Alflorone,* and related adrenal steroids in respiratory allergies, endocrine disorders, eye diseases, collagen diseases, and skin conditions. Expertly trained personnel will be pleased to discuss new dosage forms, new indications, new management technics, and the latest summaries of advanced clinical reports. A new anesthetic agent, *Cyclaine* Hydrochloride, with qualities suitable for such forms of regional anesthesia as infiltration, nerve block, spinal, caudal, and topical is of interest. Research data relative to more effective therapy when penicillin is used in conjunction with *Bencmid* completes the exhibit.

19—Slaten Instrument Company, Milwaukee

We will feature instruments and equipment of our own make as well as those of other domestic and foreign manufacturers. Several new items manufactured by us will be of particular interest to both the surgeon and general practitioner.

5—Smith, Kline & French Laboratories, Philadelphia

Our booth will feature the diverse and dramatic uses of *Thorazine* in arresting nausea, vomiting, and hiccup; in potentiating other drugs; and in treating psychiatric disturbances. Our representatives will be on hand with the latest information on *Mio-Pressin*—a truly "broad-spectrum" antihypertensive—and on the newest application of Smith, Kline & French's unique *Spansule* dosage form, *Prydon* and *Prydonnal Spansule Capsules,* for the treatment of peptic ulcer and spastic conditions of the gastrointestinal tract.

51—E. R. Squibb & Sons, New York

S-35—Swift & Company, Chicago

The original all-meat baby foods, Swift's Meats for Babies and Juniors, will be featured at our exhibit. Literature and information on clinical research will be available. Also available is information about *new* Swift's Strained Chicken for Babies. Its pleasant, mild flavor will make a delicious, taste-tempting change for any baby's diet.

S-36—Twin Viewer Company, Lake Geneva, Wis.

The new *Twin Viewer* is one of the greatest advancements in the viewing of x-ray films since the beginning of radiology. View direct, or by reflection, with maximum magnification. No distortion. Glare is eliminated because of indirect light. Don't miss seeing the new *Twin Viewer* at the State Medical Society meeting.

Booth — Company and Products

49—The Upjohn Company, Kalamazoo, Mich.

Members of the medical profession are invited to visit the Upjohn booth where members of our professional detail staff will be prepared to discuss subjects of mutual interest.

41—U. S. Standard Products Company, Woodworth, Wis.

Our professional service representatives will welcome the opportunity to acquaint you with new medications being added to our expanding line.

7—U. S. Vitamin Corporation, New York

See the "oil-in-water" demonstration of liposoluble vitamins A and D made completely water soluble . . . a vitamin technical achievement originated and developed in our laboratories. Also displayed will be three pharmaceutical firsts: *Vi-Syneral Vitamin Drops*, multivitamins in drops solution; *Vi-Syneral Injectable*, multivitamin parenteral solution; and now *Vi-Aquamin Therapeutic*, aqueous vitamins and minerals in a single capsule. Detailed literature and professional samples will be available.

47—Varick Pharmacal Company, Inc., New York

E. Fougera & Company, Inc., and Division, Varick Pharmacal Company, Inc., cordially invite physicians to discuss with professional service representatives the new preparations of importance in everyday practice. Descriptive literature and samples of all products will be available.

14—Vinyl Plastics, Sheboygan

S-2—Warner-Chilcott Laboratories, New York

Two important cardiovascular agents will be featured: *Methium*, to lower blood pressure and relieve hypertensive symptoms; and *Petritrate*, to prevent attacks in angina pectoris. *Parsidol*, a new drug for the efficient management of Parkinson's disease, will also be exhibited.

2—White Laboratories, Inc., Kenilworth, N. J.

White's *Lactofort*, unique milk-fortifying supplement, combines 1-Lysine, vitamins, and minerals. Lysine, key amino acid, is essential for optimal protein utilization, but is not adequately available in the diet of infancy and early childhood. *Lactofort* improves appetite, weight, nutrition, and muscle tone—promotes normal growth and development.

36—Winthrop-Stearns, Inc., New York

Theominal (R) *R.S.* (*Theominal* with Rauwolfia serpentina) is an alliance of the classic and contemporary in antihypertensive compounds. *Theominal R.S.* combines the vasodilator and myocardial stimulant actions of theobromine and Luminal with the moderate central hypotensive effect of Rauwolfia serpentina. Gentle sedation calms the patient and a feeling of "relaxed well being" is established. Headache and vertigo disappear as the blood pressure and pulse rate are reduced gradually.

S-5—Wyeth Laboratories, Philadelphia

Our exhibit will include *Bicillin*(R), the relatively insoluble, long-acting penicillin compound in various injectable and oral forms: *Bicillin* Injection Long-Acting, *Bicillin C-R*, *Bicillin* All-Purpose, *Bicillimycin* All-Purpose, *Bicillin* Tablets, Suspension, and pediatric Drops. Also featured will be *Ansolysen*(R), new ganglionic blocking agent for management of hypertension. Orally administered, *Ansolysen* relieves subjective symptoms, is remarkably free from side effects, and reliably lowers blood pressure.

Hosts For Guest Speakers

The following physicians will serve as hosts for our guest speakers during their visit with us in Milwaukee

Guest	Host
J. ARNOLD BARGEN	A. C. GORDER, Milwaukee
IVAN BARONOFSKY	J. M. SULLIVAN, Milwaukee
JOSEPH G. BENTON	R. G. PIASKOSKI, Wood
JOHN J. BONICA	J. W. TEMPLE, Milwaukee
JAMES A. EVANS	H. W. POHLE, Milwaukee
BRUCE FRALICK	H. G. SCHMIDT, Milwaukee
WILLIAM F. GEITTMANN	L. T. SERVIS, Milwaukee
LEE FORREST HILL	J. C. PETERSON, Milwaukee
CHARLES P. LARSON	M. B. LLEWELLYN, Janesville
HERBERT C. LEE	H. J. LEE, Milwaukee
EARL R. MILLER	R. W. BYRNE, Milwaukee
DON H. O'DONOGHUE	W. P. BLOUNT, Milwaukee
JOHN ROMANO	OWEN OTTO, Milwaukee
BEN H. SENTURIA	H. C. HIGH, Milwaukee
HARRIS B. SHUMACKER	C. M. SCHROEDER, Milwaukee
RICHARD TE LINDE	R. S. CRON, Milwaukee
GEORGE J. THOMAS	RICHARD FOREGGER, Milwaukee
ROBERT TURELL	R. T. McCARTY, Milwaukee

1955 AUXILIARY CONVENTION PROGRAM

Tuesday, May 3

P.M.

4:00–6:30 Registration, Fifth Floor, Hotel Schroeder

6:30 Board of Directors' Dinner, English Room, Hotel Schroeder

Those who attend: State Officers, State Chairmen, County Presidents and Presidents-Elect, Past State Presidents, and Honored Guests

(Dress, semiformal)

★

Wednesday, May 4

A.M.

8:00 Registration, Fifth Floor, Hotel Schroeder All doctors' wives are welcome.

9:30 Formal opening of the Twenty-Seventh Annual Meeting of the Woman's Auxiliary to the State Medical Society of Wisconsin, Pere Marquette Room, Hotel Schroeder

MRS. V. S. FALK

Mrs. Victor S. Falk, President, presiding.

Invocation—The Reverend James M. Buxton, Whitefish Bay

Pledge to Flag — Mrs. M. J. Reuter, Milwaukee

Pledge of Loyalty—Mrs. J. F. McDermott, Green Bay

Address of Welcome—Mrs. A. H. Stahmer, Wausau, President, Marathon County Auxiliary

Response to Welcome—Mrs. J. Howard Johnson, Milwaukee

Introduction of President-Elect, Mrs. J. J. Boersma, Green Bay

Introduction of Convention Chairman, Mrs. H. W. Christensen, Wausau

Convention Rules of Order—Mrs. M. A. Bailey, Fennimore

Roll Call—Mrs. E. D. Sorenson, Elkhorn

Minutes of Twenty-Sixth Meeting—Mrs. E. D. Sorenson

Reports of County Presidents of 1954–1955 (Time limit, 2 minutes)

Report on Registration—Mrs. Karl Stahmer, Wausau

P.M.

12:30 Chartered busses will leave Hotel Schroeder for the Chalet on the Lake

1:00 Luncheon, Chalet on the Lake

In Honor of Mrs. Mason G. Lawson, Little Rock, Arkansas, President-Elect of the Woman's Auxiliary to the American Medical Association; Past State Presidents; and Members-at-Large of the Auxiliary

MRS. M. G. LAWSON

Address — Mrs. Mason G. Lawson, "The Place of the Auxiliary in Our Design for Living"

Monologue — Mrs. J. V. Flannery, Wausau . . Time to shop and visit the exhibits of the State Medical Society at the Auditorium

★

Thursday, May 5

A.M.

9:00 Registration, Fifth Floor, Hotel Schroeder

9:30 General Session, Pere Marquette Room, Hotel Schroeder

Mrs. Victor S. Falk, presiding

Convention Announcements — Mrs. H. W. Christensen

Memorial Service—Mrs. J. William Boren, Jr., Marinette

Revision of By-Laws

Presented by Mrs. Sture A. M. Johnson, Madison, Chairman, Revisions Committee

New Business

Report of Nominating Committee — Mrs. C. R. Pearson, Baraboo, Chairman

Election of Officers

Installation of Officers—Mrs. Harold Wahlquist, Minneapolis, Past National President

Presentation of President's Pin—Mrs. Robert E. Fitzgerald, Milwaukee, Past President, Woman's Auxiliary to the American Medical Association

Inaugural Address—Mrs. J. J. Boersma

Final Report on Registration — Mrs. Karl Stahmer

11:00 Post-Convention Board Meeting, Parlor E, Fourth Floor, Hotel Schroeder

Mrs. J. J. Boersma, President, presiding

P.M.

1:00 Luncheon and Style Show, Crystal Ballroom, Hotel Schroeder

In Honor of County Presidents of 1954–1955 Mrs. J. J. Boersma, President, presiding . . . Time to shop and visit the exhibits of the State Medical Society at the Auditorium

5:30 Reception of the President of the State Medical Society of Wisconsin, East Room, Hotel Schroeder

MRS. J. J. BOERSMA

6:30 Annual Dinner, State Medical Society of Wisconsin, Crystal Ballroom, Hotel Schroeder

Skit: "There IS a Doctor in the House."

Woman's Auxiliary to the Fond du Lac County Medical Society

Convention Hostesses

MEMBERS OF THE WOMAN'S AUXILIARY TO THE MARATHON COUNTY MEDICAL SOCIETY

Back row, left to right: Mrs. G. R. Hammes, publicity; Mrs. W. T. Becker, convention hall; Mrs. A. H. Stahmer, tickets; Mrs. H. W. Christensen, general chairman; Mrs. H. R. Fehland, co-chairman and hostess; Mrs. G. H. Stevens, Thursday luncheon; Mrs. F. C. Prehn, flowers and place cards.

Front row, left to right: Mrs. R. B. Larsen, information; Mrs. A. O. Hendrickson, nurse recruitment project; Mrs. K. H. Stahmer, registration and credentials; Mrs. J. M. Foerster, board of directors' dinner; Mrs. E. B. Brick, Wednesday luncheon.

Upjohn

Rheumatoid arthritis, rheumatic fever, intractable asthma, allergies . . .

Cortef* *tablets*

Supplied:

5 mg. tablets in bottles of 50
10 mg. tablets in bottles of 25, 100, 500
20 mg. tablets in bottles of 25, 100, 500

*REGISTERED TRADEMARK FOR THE UPJOHN BRAND OF HYDROCORTISONE (COMPOUND F)

The Upjohn Company, Kalamazoo, Michigan

For Nasal Congestion in THE COMMON COLD

Physiologically acceptable Neo-Synephrine hydrochloride solution promptly constricts the engorged nasal capillaries which are responsible for nasal congestion in the common cold. When the nasal mucosa is reduced to its normal state, the nasal passages resume their proper patency, drainage is possible, and the patient can again breathe freely.

By its shrinking action on the nasal mucosa, Neo-Synephrine helps to keep the sinuses aerated and the openings to the eustachian tubes clear.

Neo-Synephrine within minutes produces decongestion that lasts for hours.

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Hydrochloride

0.25%, 0.5% and 1% Solution

New: Nasal Spray — Plastic Squeeze Bottle

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Neo-Synephrine (brand of phenylephrine), trademark reg. U.S. Pat. Off.

During the recent national meeting of the Blue Shield Medical Care Plans, it became increasingly apparent that the individual plans are deeply concerned with the enrollment of the so-called "national accounts." It was brought out at the meeting that employers (and others) whose employes reside in several different areas of the country ask for uniform contract provisions and a uniform method of rating costs. But Blue Shield plans are now autonomous. Varying schedules of benefits are in effect. Contract provisions differ. And equally as varied as the differences in the plans are the suggestions offered to meet the problem.

The Wisconsin delegation felt that a comprehensive study was in order. It conferred with the delegations from other plans in this district—Minnesota, Iowa, North Dakota, and Nebraska—which agreed. The result was the introduction of a resolution which, modified somewhat at the suggestion of the Reference Committee on New Business, was unanimously adopted. The text of this resolution follows.

Resolution Introduced by District Ten

Your reference committee is in full sympathy with the spirit of seeking an objective evaluation of the central functions in this organization. Your committee recommends the following substitute resolution:

WHEREAS, Blue Shield Medical Care Plans, Inc., had as its original purpose for organization the development of typical trade organization activity; and

WHEREAS, This organization has moved in a multitude of ways to the point that a basic policy question must be settled by member plans; and

WHEREAS, This question may possibly be stated most simply as follows:

Shall Blue Shield Medical Care Plans, Inc., now become a controlling central and directing organization over individual member plans, and by such control may it, for example:

a. Require individual plans to conform to certain contract specifications and contract for certain types of public offerings?
b. Order conformity within geographical areas, or nationally, to fee schedules prescribed by it?
c. Control definitions of medical service and, by such control, affect directly the practice of medicine?
d. Direct legislative activity on a national, and possibly state, level?

WHEREAS, Current trends and problems need re-analysis, objective study, and presentation to all member plans for their careful and deliberate consideration,

Now therefore be it resolved, That the Commission itself forthwith organize a special Task Force, a majority of the members of which shall be physicians who are actively engaged in the private practice of medicine,* with representation from large, intermediate, and small Plans; none of the Task Force members shall be a member of the Commission or of the Board of Directors of Medical Indemnity of America; that the Task Force shall obtain such consultation as it considers desirable, and that it maintain as close liaison with the AMA as possible. The Task Force shall examine fully into all such matters as bear upon the principal question stated above in the preamble.

This Task Force should report back to the Annual Conference of Plans.

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* The requirement that a majority of the committee be physicians "actively engaged in the private practice of medicine" was incorporated at the suggestion of Dr. J. W. Fons, Milwaukee, official voting representative of Surgical Care of Milwaukee.

News Items and Personals

Doctor Mastalir in Surgical Training

Dr. L. O. Mastalir of Burlington has taken a leave of absence from his duties to spend six months to a year in further surgical work at the Jackson Clinic and Methodist Hospital, Madison. In his absence *Dr. D. J. Baker* and Dr. Ray Doyle will have charge of the clinic which is being remodeled and enlarged at Burlington.

Dr. D. P. Epperson Addresses Rotary Club

As a new member of the Rotary Club in Watertown, *Dr. D. P. Epperson* presented a talk on January 30 at the Elks Home. He outlined the years of schooling required to qualify for the specialization of surgery.

Doctor Seidl Joins Grafton Physician

Dr. Joseph A. Seidl, formerly of Richland Center, has joined *Dr. K. F. Pelant* in his new offices at Grafton. A graduate of Marquette University School of Medicine, Doctor Seidl is in general practice.

Dr. Roy Hong Enters Military Service

Dr. Roy Hong of Wild Rose reported on February 21 at Gunter Air Force Base in Montgomery, Alabama, for a three weeks' orientation course. He then left for Parks Air Force Base in California for assignment to the 35th Tactical Hospital, Far East Air Force.

Spooner Physician Moves to Hayward

Dr. Martin H. Sahs, who practiced at Spooner since September 1948, has joined *Dr. Desmond Callaghan* and *Dr. Emil Krueger* at Hayward. He is a graduate of the University of Iowa College of Medicine and interned at Pennsylvania Hospital, Philadelphia. For the past several years he served as city health officer in Spooner.

Doctor Hammond Returns to Chetek

Dr. D. F. Hammond, who spent four months this winter in the general practice of medicine at Stromsburg, Nebraska, returned to Chetek in March. He has reopened his office in the Strong Building.

Physicians Speak to Librarians

At the annual meeting of the Wisconsin Association of Medical Record Librarians on March 14 at the Hotel Schroeder, Milwaukee, *Dr. Gunnar Gundersen,* La Crosse, spoke on medical records and hospital accreditation.

Doctor Gundersen, a trustee of the American Medical Association, is also a member of the Joint Commission on Hospital Accreditation.

Dr. Robert O'Connor of Milwaukee discussed the work of the St. Joseph's Hospital Medical Records Committee, of which he is a member. Mr. John Rankin, director of Milwaukee County institutions and departments, talked on medical records from the hospital administrator's point of view.

Menomonie Hospital Staff Officers Elected

When the medical staff of the Memorial Hospital, Menomonie, met on February 2, *Dr. A. A. Drescher* of Menomonie was elected president for the new year. *Dr. P. W. Limberg* of Glenwood City was elected vice-president; and *Dr. R. J. Gardner* of Menomonie was chosen secretary.

Dr. Arthur McCarey Renamed President of City Board of Health

Dr. Arthur J. McCarey, Green Bay, president of the State Medical Society, has been renamed president of the Green Bay Board of Health. When he became president of the State Society last year, he resigned as president of the Board; however, as his term as president of the Society will expire in May, he has again accepted the Board responsibility. The meeting at which he was renamed was held on February 14.

Green Lake Cancer Group Hears Doctor Johnson

At a noon luncheon meeting of the Green Lake County cancer workers at the Republican House, Ripon, on March 9, *Dr. J. M. Johnson* of Ripon was the guest speaker. Mr. Robert O. McLean, executive director of the Wisconsin division of the American Cancer Society, presented films on cancer research at the McArdle Laboratory in Madison.

Doctor Van Driest Attends Orthopedic Meet

Dr. J. J. Van Driest of Sheboygan recently spent two weeks in California, where he attended a meeting of the Academy of Orthopedic Surgeons. The meeting was held in Los Angeles.

Doctor Klaas Attends Videclinic at Minneapolis

Dr. F. B. Klaas of East Ellsworth attended a Videclinic at the Radisson Hotel, Minneapolis, on February 9. This nation-wide television clinical conference on "The Management of Coronary Artery

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COOK COUNTY GRADUATE SCHOOL OF MEDICINE

Intensive Postgraduate Courses

STARTING DATES, SPRING 1955

SURGERY—Surgical Technic, Two Weeks, April 18, May 2
Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, June 6
Surgical Anatomy & Clinical Surgery, Two Weeks, June 20
Surgery of Colon & Rectum, One Week, May 9
General Surgery, Two Weeks, April 25; One Week, May 23
Gallbladder Surgery, Ten Hours, June 27
Thoracic Surgery, One Week, June 6
Esophageal Surgery, One Week, June 13
Fractures & Traumatic Surgery, Two Weeks, June 13

GYNECOLOGY—Office & Operative Gynecology, Two Weeks, April 18, June 13
Vaginal Approach to Pelvic Surgery, One Week, May 2

MEDICINE—Two-Week Course, May 2
Electrocardiography & Heart Disease, Two Weeks, July 11
Gastroenterology, Two Weeks, May 16
Dermatology, Two Weeks, May 9
Hematology, One Week, June 13

RADIOLOGY—Diagnostic Course, Two Weeks, May 2
Clinical Uses of Radio Isotopes, Two Weeks, May 2
Radium Therapy, One Week, May 23

PEDIATRICS—Intensive Course, Two Weeks, April 11
Clinical Course, Two Weeks, by appointment
Neuromuscular Diseases, Two Weeks, June 20

UROLOGY—Two-Week Urology Course, April 18
Ten-Day Practical Course in Cystoscopy every two weeks

Teaching Faculty—Attending Staff of Cook County Hospital

ADDRESS: REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

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THIRD AND TWELFTH DISTRICTS NEWS

Doctor Curreri Speaks at Waukesha

Dr. A. R. Curreri, associate professor of surgery and director of the tumor clinic at the University of Wisconsin Medical School, Madison, spoke at the Founders Day dinner meeting of the Waukesha County University of Wisconsin Alumni Association on February 24. The meeting was held at the Avalon Hotel, Waukesha.

Doctor Curreri's topic was "The Development of the University of Wisconsin Medical School and Its Relationship to the State."

Doctor McKenzie Joins Dr. D. L. Williams

Dr. L. J. McKenzie, a 1948 graduate of the University of Wisconsin Medical School, has joined *Dr. D. L. Williams,* Madison, in the practice of obstetrics and gynecology. Doctor McKenzie interned at Ancker Hospital at St. Paul and took a year of advanced training in pathology at White Cross Hospital, Columbus, Ohio. He spent six months in specialization at Methodist Hospital, Dallas, Texas, and then served two years in the Army. Upon his discharge, he returned for two years of further training in his specialty at Milwaukee County Hospital, Milwaukee, before locating in Madison.

Dr. E. M. Burns Affiliated with Madison Neuropsychiatric Associates

The Madison Neuropsychiatric Associates have announced the affiliation of *Dr. E. M. Burns.* Doctor Burns graduated from the University of Illinois College of Medicine, Chicago, in 1937. Most recently, he had been clinical director of Mendota State Hospital and formerly was assistant professor of psychiatry at the University of Wisconsin.

Doctor Watzke Returns from Service

Dr. Donald Watzke, who has been in military service in Alaska for the past two years, received his discharge in February. He has returned to his home in Madison.

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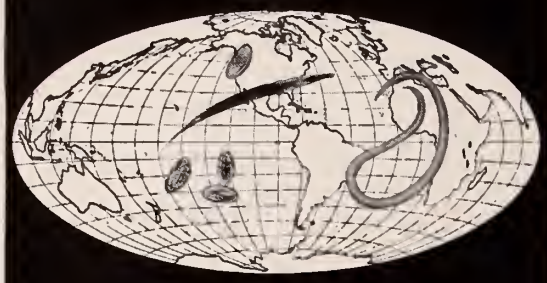

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Dr. Arthur W. Hankwitz Moderator of Panel

At a meeting of the Civic Alliance in the City Club, Milwaukee, February 11, *Dr. Arthur W. Hankwitz*, Milwaukee, was moderator of a panel discussion on "Health and Sanitary Problems in Metropolitan Milwaukee." Speakers on the panel were *Dr. John S. Hirschboeck*, dean of the Marquette University School of Medicine; Mr. J. F. Wisniewski, State Board of Health; and Mr. Roger A. Sutherland of the city sewerage commission.

Marquette Conducting General Practice Course

A 16-hour postgraduate course on medical consultation in small industry began on March 3 at the Marquette University School of Medicine. Sessions are being held weekly through April 21 for general practitioners and interns. The course is sponsored in cooperation with the Wisconsin Academy of General Practice and the Medical Society of Milwaukee County. *Dr. E. L. Belknap*, director of the medical school's Department of Occupational and Environmental Medicine, is director of the course.

Doctor Suckle Speaks to Iowa Group

Dr. Henry Suckle of Madison addressed the members of the Dubuque County Medical Society, Dubuque, Iowa, on February 8. The title of his talk was "Head Injuries."

SOCIETY RECORDS

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W. E. Curtis,* 118 South Main Street, Elroy.

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D. A. Franklin, V. A. Hospital, Wood.

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E. P. Schuh, Tigerton.

G. E. McGuire,* 122 East Walnut Street, Green Bay.

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R. A. Lende, Montreal Neurological Institute, Montreal, Quebec, Canada.

L. J. McKenzie, 16 North Carroll Street, Madison.

K. L. Siebecker,* 1222 Shorewood Boulevard, Madison.

C. F. Schroeder,* 16 South Henry Street, Madison.

R. F. Finegan, 605 East Johnson Street, Madison.

B. M. Polcyn,** Cas. Off. Sec., 1264th S. U. Perscen, Camp Kilmer, New Jersey.

W. F. Weingart,* 4126 North 14th Street, Milwaukee.

S. B. Gundersen, Jr., 1836 South Avenue, La Crosse.

Kaare Getz, Department of Dermatology, Mayo Clinic, Rochester, Minnesota.

R. A. Sundeen, 120 Blossom, Ripon.

A. R. MacEwen, 1910 South Avenue, La Crosse.

C. G. Grauer, 404 Third Street, Wausau.

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Changes of Address

R. J. Becker,** Columbus, Georgia, to 16th Medical Det., A.P.O. 751, % Postmaster, New York, New York.

C. W. Crawford,** Green Bay, to 10309 Huson Street, Tacoma 99, Washington.

J. A. Means, % Postmaster, San Francisco, California, to 1000 South 48th Street, Milwaukee.

D. J. Malloy, Maywood, Illinois, to 208 East Wisconsin Avenue, Milwaukee.

D. E. Matthiesen,** Corpus Christi, Texas, to 712 East State Avenue, Phoenix, Arizona.

R. W. Schroeder, Milwaukee, to 330 Ledgeview Avenue, Fond du Lac.

F. S. Selle, Milwaukee, to Route 6, Box 843, Waukesha.

M. S. LeTellier, % Postmaster, San Francisco, California, to 1292 North 63rd Street, Milwaukee.

R. E. Bolinske,** Clintonville, to 419 Babb Drive, Midwest City, Oklahoma.

D. J. Freeman, Wausau, to 1331 Drake Street, Madison.

J. A. Seidl, Richland Center, to 1240 13th Avenue, Grafton.

W. L. McLane, Gilman, to University of Illinois Health Service, 807 South Wright Street, Champaign, Illinois.

L. O. Mastalir, Burlington, to 16 South Henry Street, Madison.

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

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Brown, H. W.: J. Pediat. 45:419, 1954.

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J. P. Miller, Wright–Paterson Air Force Base, Ohio, to 2457 Cedar Street, San Bernardino, California.

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DEATHS

Dr. Frank Leslie Fancher, 102 years of age, died on February 22 at his home in Racine, where he had practiced until 1949.

He was born on September 5, 1852, in Racine and was graduated from Bennett Medical College, Chicago, in 1885. Prior to studying medicine he sold drugs in Racine, and a few years following his graduation from medical school, he left his practice in Racine to study dentistry in Chicago. In 1889 he returned to his home community to practice dentistry for more than 60 years.

His wife preceded him in death in 1949. He is survived by a daughter, Mrs. Winnie Desmarais of Racine; a brother; five grandchildren; 11 great-grandchildren; and one great-great-grandchild.

Dr. Henry F. Schroeder, Marinette, passed away at his home on February 12. Born on August 11, 1870, at Elizabethtown, Pennsylvania, he was 84 years of age at the time of his death.

He was graduated from the Medico-Chirurgical College of Philadelphia in 1899. He interned at Philadelphia County Hospital the following year and established his practice at Marinette in 1901.

He was a charter member of the Marinette–Florence County Medical Society and a member of the State Medical Society of Wisconsin and the American Medical Association. In 1950 he was made a life member of the State Society.

Doctor Schroeder had served as president of his county society for many terms and had been a delegate and alternate delegate from his county society to the House of Delegates of the State Society on several occasions.

In December 1948, he was honored by the Kiwanis Club "for 48 years of healing the sick and relieving those in pain, for leadership in providing medical care for students, and for stimulating the medical profession in its never-ending battle against disease."

Doctor Schroeder served as medical advisor to the Wisconsin Interscholastic Athletic Association for many years and had been city physician in the past.

He is survived by his widow, Stella, and one sister, Mrs. Catherine Hershey of Marinette.

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Dr. Wilson Wellington Hume, Milwaukee eye, ear, nose, and throat specialist, died at a Milwaukee hospital on February 27. He was 69 years of age.

Doctor Hume was born on June 2, 1885, in Ontario, Canada; and he received his medical education from the University of Ontario, graduating in 1910. He interned at St. Luke's Hospital, Chicago, the following year, and from 1914 to 1916 received further training at the Manhattan Eye, Ear, and Throat Hospital, New York.

He had practiced at Vancouver, British Columbia, and Rockford, Illinois, before moving to Milwaukee 32 years ago. During a two-year period from 1917 to 1919 he served in the Medical Corps of the U. S. Army.

Doctor Hume was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Flora, and a son, Robert F., Milwaukee.

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Dr. Edwin Mortimer Tillson, 82-year-old Milwaukee physician, died on March 3 while vacationing at Miami, Florida. He had retired from active practice a few years ago.

Doctor Tillson was born at Manitowoc on August 29, 1872. He received his medical degree from the College of Physicians and Surgeons of the University of Illinois in 1895, and began his practice at Two Rivers. Later he did postgraduate work in hospitals in New York City and London for several years.

After finishing his postgraduate work, Doctor Tillson moved to Milwaukee; he served as a school physician for the city school system as well as maintaining his own office. He was a member of the staff of Milwaukee Hospital.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Doctor Tillson never married; he is survived by two sisters with whom he lived, Mrs. Elizabeth Jackson and Mrs. Blanche Hibbert.

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THE WISCONSIN MEDICAL JOURNAL

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Volume 54 MAY 1955 Number 5

A Case of Cardiopulmonary Trichinosis with Recovery

By E. R. DANIELS, M. D., and ELAINE K. PEDERSEN, M. D.
Milwaukee

Fig. 1—Chest x-ray taken on June 25, 1951, revealing dense bilateral infiltration originating in hilar regions and extending throughout both lung fields in "sunray" pattern.

Fig. 2—Chest x-ray taken on June 29, 1951, showing some increase in involvement of lung to include an area above the angle of the diaphragm on the left.

BRONCHOPNEUMONIA and myocardial insufficiency frequently cause death in trichinosis. We wish to report the case of a patient who recovered from these complications of the disease.

Case Report

The patient, first seen on June 25, 1951, was an acutely ill, 29-year-old, white female. For several years she had had frequent colds and much sneezing. Six weeks prior to her admission a cough developed; it was dry for four weeks and productive thereafter. Coughing paroxysms were more frequent in the morning. She had had dyspnea on exertion for two weeks and bilateral lower chest pain at intervals. Headaches, anorexia, and constipation were recent complaints. The patient was fond of raw beef.

She was pallid, had extreme shortness of breath on slight effort, and coughed frequently; the ali nasi moved forcibly on respiration. The temperature was 99 F.; the pulse rate, 120 per minute; respirations, 40 per minute; and blood pressure, 95/56. Respiratory excursions were limited. Tactile fremitus was increased over the right lung field. Hyperresonance and coarse inspiratory rales were heard over both lungs posteriorly. A chest x-ray on June 25, 1951, revealed a dense bilateral infiltration originating in the hilar regions and extending throughout both lung fields in a "sunray" pattern. The patient had leukocytosis of 16,500, with 38 per cent eosinophils.

Fig. 3—Chest x-ray showing densities in both lung bases with a small amount of fluid in right pleural space.

Chloromycetin, penicillin, and Dihydrostreptomycin were given. The patient improved clinically, but an x-ray of the chest on June 29 showed some increase in the involvement of the lung to include an area above the angle of the diaphragm on the left (Fig. 2). On July 3, the former treatment was discontinued; and potassium iodide, Aureomycin—250 mg. every four hours orally—benadryl, and oxygen therapy were given.

On July 9, resolution was evident on the roentgenogram. Oxygen therapy was discontinued. However, a low-grade fever of 99 to 100 F. persisted. On July 10, evidence of myocardial damage was shown by the electrocardiogram. The x-ray of the chest was normal on July 18, and the patient returned home afebrile and clinically well. She had a mild hypochromic anemia, 10,100 white blood cells per cubic millimeter, and a 21 per cent eosinophilia. An electrocardiogram on July 25 gave evidence of coronary insufficiency.

Sputum examinations were negative for tubercle bacilli, and the tuberculin skin tests were negative. Cold agglutinens were negative; the Weil–Felix reaction and complement fixation tests for murine typhus, Rocky Mountain spotted fever, rickettsialpox, Q fever, and lygranum were negative. Serum titers for influenza A, A′, and B were within normal limits.

On August 26, 1951, another upper respiratory infection developed. The patient had "sniffles and sneezes" and a tickling sensation in her chest, causing her to cough. Headache returned over the vertex, usually in the morning, and was relieved by aspirin; the patient complained of occasional scotomata. Stiffness of the neck and aching in the shoulder and extremities that disturbed her sleep also developed. Shooting pains were felt over the left anterior chest at times, but she experienced no shortness of breath. Her appetite was good, and she had regained some of the weight lost during the illness of the previous month.

On September 3, 1951, she was again hospitalized. At this time we learned that early in June, two weeks prior to the first hospital admission, some of the members of her family had become ill after a meal of poorly cooked pork. The patient now appeared well. Her temperature was 99 F.; her pulse rate, 78 per minute; and respirations, 18 per minute. Rales over both posterior lung bases, a very faint systolic murmur over the apex of the heart, and questionable splenic enlargement were found. The fingernails, more convex than usual, had red linear markings under the distal portions. There was no neurological abnormality. The pelvis was normal.

A chest x-ray showed densities in both lung bases with a small amount of fluid in the right pleural space (Fig. 3). An electrocardiogram on September 4 showed ST depression in the standard leads II and III and proximal inversion of the T waves. Sodium salicylate and ferrous gluconate was begun on September 6, at which time the hypochromic anemia was again apparent. The anemia responded to therapy and the fever disappeared, but the discomfort in the shoulders persisted. Potassium iodide and Aureomycin were given again. On September 10, the patient stated she was much better. The shadows seen in the chest x-ray were less dense, but the diaphragmatic excursions were reduced.

Splinter hemorrhages of the nail beds were again noted on September 12. The electrocardiogram of this date showed low R complexes in standard I and $V_{5,6}$, depressed ST segments and proximally inverted T

waves in standard leads II and III, AVF, and $V_{1, 2, 3, 4}$ (Fig. 4). Tuberculin skin tests were again negative. Trichinosis intradermal skin tests were slightly indurated in 20 minutes and were clear in 24 hours. This was interpreted as negative.

Eosinophilia averaged 27 per cent throughout the patient's hospitalization. Sedimentation rates were consistently elevated. The following blood protein values were present:

Date	Total Protein	Albumin	Globulin	A–G ratio
September 5	4.42	2.75	1.67	1.65–1
September 11	8.7	4.95	3.75	1.3 –1

Multiple stool examinations were negative. Blood agglutinations for brucella, typhoid, and paratyphoid were negative. Blood cultures were negative. Bone marrow examination contributed only eosinophilic hyperplasia. Muscle biopsy of the right gastrocnemius muscle revealed cysts of the Trichina larvae.

The patient was discharged on September 15, 1951, to convalesce at home. She has had no further acute episodes. Iron therapy was continued until June 1952. The eosinophil count was normal in October 1952. The electrocardiogram was normal in June 1952.

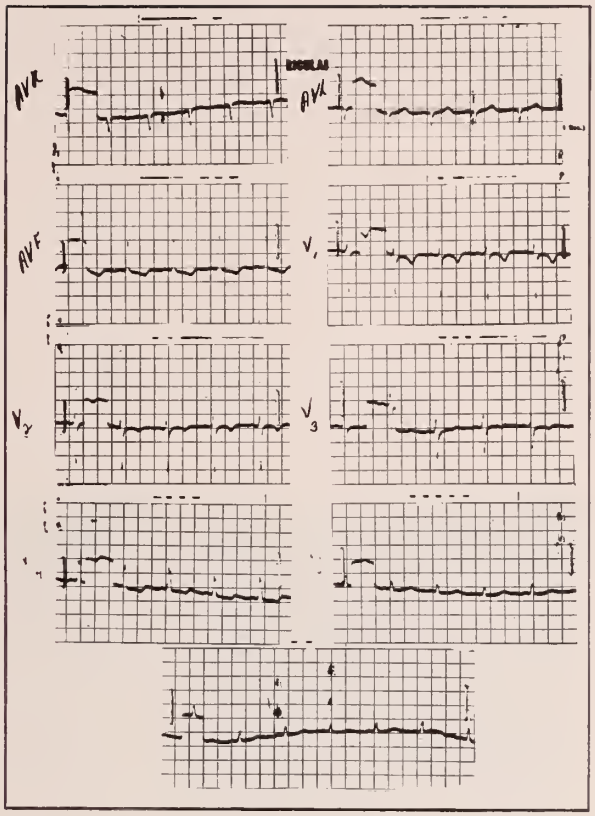

Fig. 4—Electrocardiogram of September 12, 1951.

Comment

Trichinosis usually goes through three stages. The stage of invasion lasts two to seven days and is characterized by gastrointestinal symptoms. The stage of migration lasts from the seventh day to the end of the fifth week and includes edema about the eyes, splinter hemorrhages, muscle pain, fever, and eosinophilia. The stage of convalescence corresponds to larval encystment.

In our patient the first stage was not characteristic. The first symptoms she complained of were respiratory. In fact, the gastrointestinal phase was so unimportant in the mind of the patient that we did not get the history of the illness following the raw pork ingestion until three months later, during her second siege of respiratory and cardiac involvement. Edema of the eyelids, usually a helpful sign, also was absent. Otherwise, the clinical course was quite typical, with the eosinophilia, splinter hemorrhages, muscle pains, pulmonary and cardiac involvement.

The first important monograph on clinical trichinosis, written in 1866, included reports of 280 patients.[1] The usual symptoms were muscle pain, edema of the face, and edema of the extremities. In an epidemic of 28 cases in Rock County, Wisconsin, in 1943,[2] four patients had negative skin tests, three had cardiovascular involvement, and one had supradiaphragmatic x-ray densities. The eyes of all but three were affected. In 705 cases reported in 1946,[3] edema of the eyelid, headache, fever, and muscle pain were the usual complaints.

Gould found normal sedimentation rates and no splenic enlargement.[1] In 1951,[4] it was reported that there was no correlation between positive skin tests and the eosinophilia of trichinosis. Gould[1] found that immediate intradermal tests were positive in 70 to 100 per cent of patients with recent infections. Negative skin tests are believed to indicate a poor prognosis.

Bronchopneumonia and myocardial insufficiency are the most frequent causes of death. A case similar to ours was reported in 1950;[5] in that case, the dyspnea and cyanosis were thought to be due to cardiac failure secondary to the myocardial invasion, whereas in our patient these symptoms undoubtedly were due to the pulmonary involvement. The

pneumonia was considered as allergic, caused by infiltrations similar to those described by Loeffler.

(E. R. D.) 425 East Wisconsin Avenue.

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Trichiniasis and the Tonsil

By PHILIP G. PIPER, M. D., and BENJAMIN I. BRINDLEY, M. D.
Madisan

Fig. 1a—Section of tonsil showing three encysted Trichinae spirals in the muscle bundle attached to the right tonsillar capsule (X 100).

Fig. 1b—Encysted Trichina spiral within the muscle bundles of the left peritonsillar crypt (X 200).

THE Trichina organism may lodge in any tissue of the body. One of the most rare locations is the tonsillar crypt. We wish to report our experience with a case in which the organism was located in this crypt.

Case Report *

A 28-year-old, white female entered the hospital because of frequent sore throats and headaches which had begun a few years previously. A postnasal drip bothered her occasionally and caused coughing in the morning, during which time she raised thick phlegm. The dull throbbing headaches seemed to be located mostly on the right side. She was sensitive to penicillin.

The sinuses were clear to transillumination. The tonsils were dull red and cryptic. Many cervical nodes were palpable, but they were not tender.

The provisional diagnosis was chronic tonsillitis and chronic sinusitis.

The patient's blood count showed 3,910,000 erythrocytes, 8,050 leukocytes, and a differential count of 45 per cent neutrophils, 45 per cent lymphocytes, and 1 per cent eosinophils. Her hemoglobin was 12.2 Gm. Her bleeding time was 2 minutes, and the clotting time was 5.5 minutes. The urine was normal.

* From the Department of Pathology and Otolaryngology, Madison General Hospital, Madison.

A tonsillectomy was done under local anesthesia. Postoperative recovery was uneventful, and the patient was discharged 24 hours after admission.

The tonsils were 2.5 x 2 x 1.5 cm. and 2.5 x 1.5 x 1 cm., respectively. The cut surfaces were grayish-white and lobular and had many tiny yellow areas. In the sections, plasma cells, lymphocytes, and occasional polymorphonuclear leukocytes appeared, both around and within the crypts. The vessels were moderately engorged; and patchy areas of connective tissue, usually trabecular in arrangement, were seen. The size and relative number of secondary nodules were increased, indicating hypertrophy. Within the skeletal muscle of the peritonsillar crypt of each tonsil which was attached to the capsule were found encysted Trichinella spiralis associated with calcification and chronic inflammation (Figs. 1a and 1b).

Discussion

The etiological agent of trichinosis was first discovered in the encysted stage in the muscles of patients autopsied in London by Peacock (1828), Hilton (1833), and Paget (1835).[1] Since then the clinical and pathological manifestations of this infestation have been intensively studied and widely publicized. The literature contains descriptions of the many bizarre forms which the infestation may take. Jacobson[2] reported two patients with bilateral pulmonary consolidation; one of these patients had effusion. Jacobs'[3] review of trichinous myocarditis described Zenker's first observation of Trichina larvae in the myocardium of fatal cases in 1860. Prym[4] demonstrated encysted larvae in the myocardium and living larvae in the pericardial fluid. Solarz[5] found electrocardiographic evidence of myocardial damage in 24 of 114 patients with trichinosis. Fetchko, Weber, and Carroll[6] reported a case of trichinosis complicating pregnancy and warned that pyrexia during labor may indicate trichinosis.

Wilkinson,[7] in a study of 10,000 pairs of tonsils, reported six cases of trichinosis; and Starry[8] found one case of the infestation in a review of 8,516 tonsils. In all of these, as in our case, the Trichina was found in the capsular tissue on the trabecular fibrous muscle septa.

Arkman[5] said that the abundant vascular supply in the peritonsillar striated muscle is favorable to the settlement of Trichina. This area is no doubt involved much more frequently than the reports indicate. The lesions would be found more often if the specimens for tonsil operations were routinely examined. In many of the previously reported cases, the tonsillectomies were done for relief of muscular rheumatism, the cause of which was actually trichinosis.

Whether or not our patient's headaches were due to central nervous system trichinal involvement must be left to conjecture. Infestation of the brain and meninges has been observed in some patients.

Eosinophilia of 30 to 50 per cent is usually found; our case was not typical in this respect. It also was unusual in that the patient had no symptoms of trichinosis. Greene and Breazeale[9] reported many such asymptomatic cases; they used the specific Kline test to make the diagnosis.

According to Senter,[10] an equivocal diagnosis can be made if the patient has eosinophilia, a positive skin test, and a positive complement fixation or precipitin test; but a definite diagnosis cannot be made unless the organism is found.

(P. G. P.) 925 Mound Street.

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Gargoylism: Two Cases in Siblings*

By FRANK C. STILES, M. D.
Monroe

GARGOYLISM, also known as dysostosis multiplex, lipochondrodystrophy, or Hurler's syndrome, was described by Gertrud Hurler in 1919; two years earlier, however, Hunter[1] described the skeletal deformities in a report of the occurrence of the disease in two brothers. Children with this condition usually have dwarfism, mental retardation, grotesque features, cloudy corneas, lumbar kyphosis, enlargement of the liver and spleen, umbilical hernia, and rigid joints. X-ray studies frequently show deformities of the lumbar vertebrae, thickening and irregularity of the long bones, clawlike deformities of the hands, and enlarged sella turcica. Caffey[2] described generalized severe demineralization of the skeleton as an early finding in patients who later showed the clinical characteristics of gargoylism.

This condition often seems to be transmitted by a recessive gene, and both parents would have to be carriers of such genes in order to produce a child with gargoylism. Thus, this syndrome can easily occur in siblings but is rarely transmitted from one generation to another.

Deposits of an abnormal substance in many tissues throughout the body have been demonstrated. These deposits were first thought to be lipoid in nature and thus the term "lipochondrodystrophy" was used as a synonym of gargoylism.

The exact nature of the abnormal intracellular deposits is still a matter af conjecture. These deposits are found in the epithelial cells of the liver, epidermis, and glands of the skin; in the reticuloendothelial cells of the spleen and lymph nodes; and in nerve cells throughout the nervous system. The deposits have been thought to be glycogen; glycoprotein; a complex polysaccharide; or the cerebrosides, phrenosin and/or kerasin.[3-5] There is no satisfactory treatment for gargoylism.

Case Reports

Case 1—T. M., a five-year-old white male was admitted to Milwaukee Children's Hospital on May 22, 1952, because of retarded speech and mental development since one year of age. The boy had seemed "overactive" and failed to learn from experience. His physician, suspecting thyroid abnormality, referred the child for study.

Fig. 1—T. M., a five-year-old child with gargoylism.

His mother's health during her pregnancy was good. The infant was born at full term, and the delivery was normal. He had measles at three years of age but no other illness. One sibling of four years had similar difficulties (See Case 2). Both parents were normal, healthy adults. No other members of the family were known to have the affliction.

The boy did not walk until 13 months of age. The date his first tooth erupted and the date of sitting alone were not known. The child never learned to talk. His height and weight had followed a normal growth pattern.

* From Milwaukee Children's Hospital, Milwaukee.

Fig. 2—J. M., four-year-old sibling with gargoylism.

Fig. 3—X-rays of hands of T. M. showing characteristic features of gargoylism.

Fig. 4—X-rays of hands of J. M.

Physical examination on admission showed a very irritable, hyperactive, five-year-old, white male with thick, coarse features. The hair was dry and coarse. The face was broad and flat; the forehead was prominent; the nose was extremely small and "turned up." The lips were thickened and bright red. A thick, protruding tongue was present. There was widening of the interspaces between the teeth. The boy could speak only in unintelligible monosyllables ("baby talk"). The neck was short. The abdomen was prominent, and there was marked enlargement of the liver and the spleen. The hands were broad, short, and spadelike; the fingers were thick at the base but tapered markedly.

Ophthalmoscopic examination of the fundi revealed a lack of development of the vessels of the eyes. A congenital lack of myelinization was also noted.

Laboratory studies, including a blood cholesterol of 238 mg. per hundred cubic centimeters, were normal.

A roentgenological examination revealed some interesting features. The skull was depressed anteriorly in the region of the inion. The sella turcica appeared normal. The metacarpals and phalanges were short and broad with some evidence of triangulation. The bone age of the wrists was three years (the chronological age was five years). A lateral film of the dorsolumbar spine showed deformity of the anterior portion of the second lumbar vertebra. All vertebral bodies appeared somewhat convex. There was widening of the mid-portions of the shafts of both humeri. Periosteal thickening along the lateral aspects of the femoral shafts was obvious. Both radii and ulnae were abnormally curved and bowed laterally.

Case 2—J. M., the only sibling of the child described in Case 1, was seen at the age of four years. The clinical picture was almost identical to that of the older brother. The boy could not talk and had no established bowel control. The facial characteristics, deformities of the hands, and enlargement of the liver and spleen were as pronounced in this

child as in his brother. The wrist bone age was approximately two years and three months. Laboratory studies were normal.

The Monroe Clinic.

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UPPER MICHIGAN MEDICAL SOCIETY CONVENTION

June 17 and 18, Gateway Hotel, Land O'Lakes

PROGRAM

Friday, June 17

8:00 a.m. Registration at Gateway Hotel
Exhibits open at Gateway Inn
9:00 a.m. Convention opens at Gateway Inn
Panel on Cancer arranged by Michigan Cancer Coordinating Committee
Moderator: H. M. Nelson, M. D., Assistant Professor of Obstetrics and Gynecology, Wayne University, Detroit
Early Diagnosis—Doctor Nelson
Cancer of Colon—J. A. Ferguson, M. D., Grand Rapids
Cancer of Breast—E. T. Thieme, M. D., Surgeon, St. Joseph's Hospital, Ann Arbor
10:00–11:00 a.m. View Exhibits
10:30 a.m. Pitfalls in Abdominal Surgery
F. A. Coller, M. D., Professor and Head, Department of Surgery, University of Michigan Medical School
11:00 a.m. Present-day Trends in Use of Hormones in Allergic Disease
J. M. Sheldon, M. D., Professor of Medicine, University of Michigan Medical School
11:30 a.m. Infantile Eczema
H. A. Towsley, M. D., Professor of Pediatrics, University of Michigan Medical School
12:00 noon Luncheon—Gateway Inn
1:30 p.m. Difficulties Arising in the Surgical Treatment of the Biliary Tract
F. A. Coller, M. D.
2:00 p.m. Pre- and Post-menopausal Bleeding
R. S. Cron, M. D., Clinical Professor and Director, Department of Obstetrics and Gynecology, Marquette University School of Medicine, Milwaukee
2:30 p.m. Errors in Treatment of Commoner Skin Diseases
H. R. Foerster, M. D., Clinical Professor and Director, Department of Dermatology, Marquette University School of Medicine, Milwaukee
3:00 p.m. View Exhibits
3:30 p.m. Urticaria—Morphological Characteristics and Treatment
J. M. Sheldon, M. D.
4:00 p.m. Prolonged Labor
T. N. Evans, M. D., Assistant Professor of Obstetrics and Gynecology, University of Michigan Medical School

Saturday, June 18

Moderator: F. J. Hirschboeck, M. D., Duluth Clinic, Duluth, Minnesota
9:00 a.m. Periodic Health Appraisal
J. D. Rodger, M. D., Bellaire, Michigan
9:30 a.m. Modern Developments in Convulsive Disease Therapy
Z. Stephen Bohn, M. D., Assistant Professor, Neurology, Wayne University, Detroit
10:00 a.m. Low Back Pain
W. L. Bickel, M. D., Section on Orthopedic Surgery, Mayo Clinic
10:30 a.m. View Exhibits
11:00 a.m. Injection Versus Surgical Treatment of Hemorrhoids
W. A. Fansler, M. D., Professor of Surgery, University of Minnesota Medical School
11:30 a.m. Medical Treatment of Hypertension
R. M. Schick, M. D., Section on Vascular Diseases, Mayo Clinic

For Reservations and Further Details Write: Paul R. Lieberthal, M. D., 104 South Suffolk Street, Ironwood, Michigan

Treatment of Chest Injuries*

By WILSON WEISEL, M. D.**
Milwaukee

CURRENT therapeutic concepts of chest trauma have developed largely from experiences in World War II[1, 2] and from fundamental contributions by Yates[3] and his group during World War I.

Adequate treatment in thoracic injury depends on:

1. An open airway
2. Mobility of chest wall
3. Pleural cohesion
4. Correct diagnosis
5. Prompt institution of treatment.

All chest injuries, whether simple wall bruises or severe crushing wounds, cause increased bronchial secretions and interfere with evacuation of bronchial contents because of diminished tussive effect.[4] The loss of effective cough may be due to pain and reflex splinting of the thorax or to altered ventilation mechanics. Whatever the cause, unless the airway is kept open, the end results are bronchial obstruction, pulmonary atelectasis, and asphyxia.

It is most important, then, to keep the air passages open. In most cases, the physician can do this by simple endobronchial toilet. It may be necessary to resort to bronchoscopy or, in rare instances, to tracheotomy. A suction catheter, introduced through an endotracheal tube as a guide (Fig. 1), is the best means of evacuating bronchial secretions. Bronchoscopy is frequently necessary to remove blood clots and mucus plugs from the bronchi and to diagnose bronchial injury.[5] Tracheotomy may be lifesaving for some patients. It provides easy access for aspiration and reduces the airway dead space. The patient with a tracheotomy requires constant attendance. These procedures must be done before irreversible changes have occurred in the lung.

Motion of the chest wall and diaphragm are essential for pulmonary ventilation. Retention of this mobility is particularly important after thoracic injury. The chest should not be strapped, nor should anything else be done to immobilize the chest. It has been my experience that most patients can be helped to attain normal chest motions by encouragement and by physiotherapeutic exercises provided their pain is controlled by intercostal nerve blocks (Fig. 2). Rapid rehabilitation and prompt relief from pain can be accomplished by these measures. On the other hand, the patient with an immobilized chest has a long and miserable convalescence.

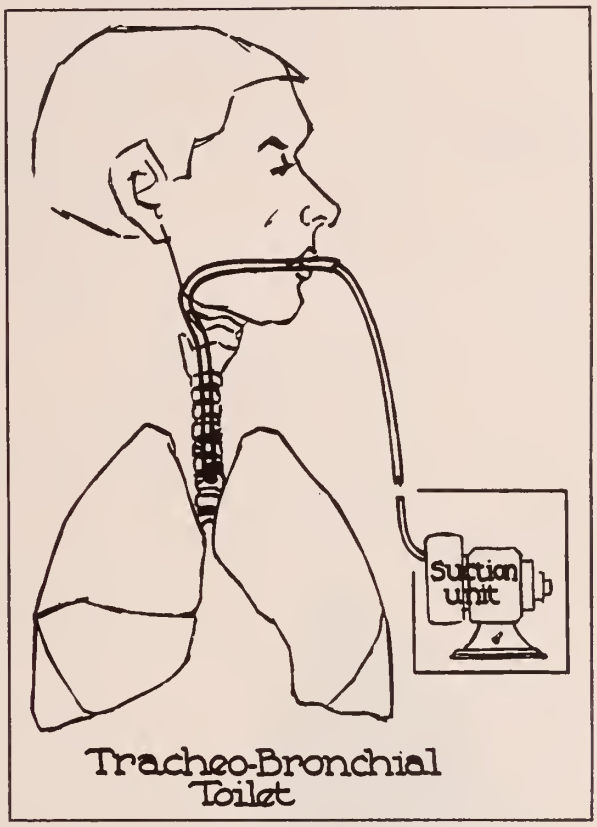

Fig. 1—Evacuation of bronchial secretions with suction tube introduced through endotracheal tube.

In the normal thorax, cohesion of the visceral pleura of the lung and the parietal pleura of the chest wall is maintained by negative intrapleural pressure and the forces producing expansion of the lung. Since this normal relationship may be disturbed by the introduction of either air or blood into the pleural space, it is essential that these substances be removed. Blood (Fig. 3) should be

* From Department of Surgery, Marquette University School of Medicine, Milwaukee.

** Assistant Clinical Professor of Surgery, Marquette University School of Medicine.

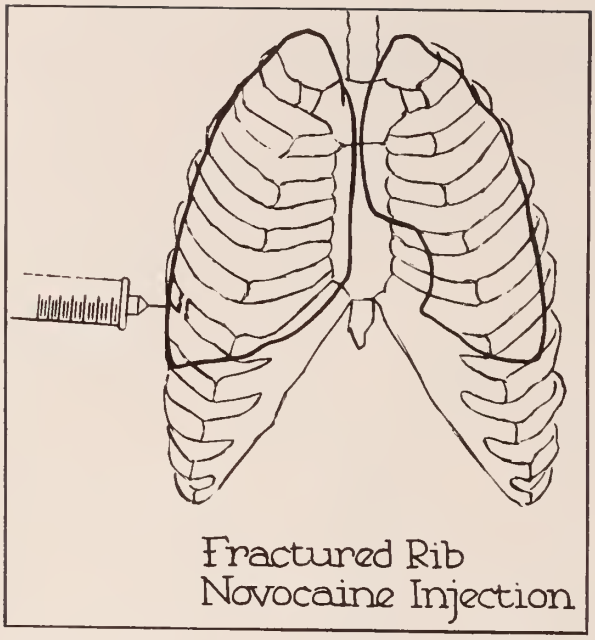

Fig. 2—Intercostal nerve block effected by injecting 1 per cent Novocaine posterior to and below rib injury.

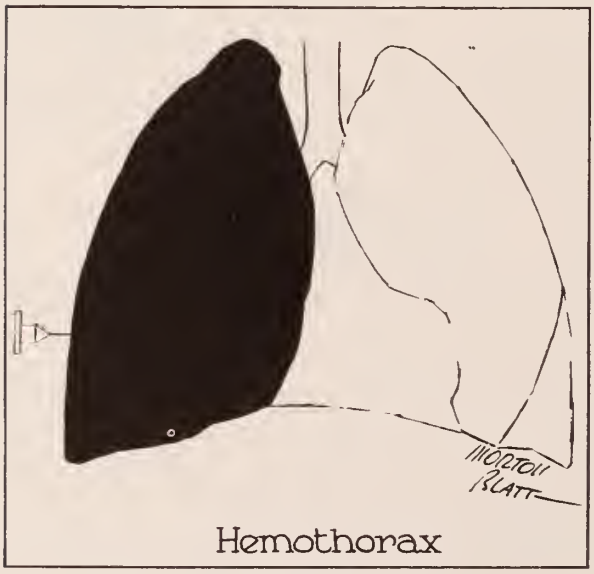

Fig. 3—Removal of pleural blood with syringe and needle.

immediately and completely aspirated in order to prevent such complications as clotted hemothorax, captive lung, chronic fibrothorax, and empyema.[6-9] Even air in the pleural space is an irritant and, when under pressure, is a threat to the life of the patient. The air should be removed; this can be done by aspirations, but a safer procedure in most instances is subaqueous decompression of the thorax by a catheter (Fig. 4) introduced into the pleural space through a trocar.

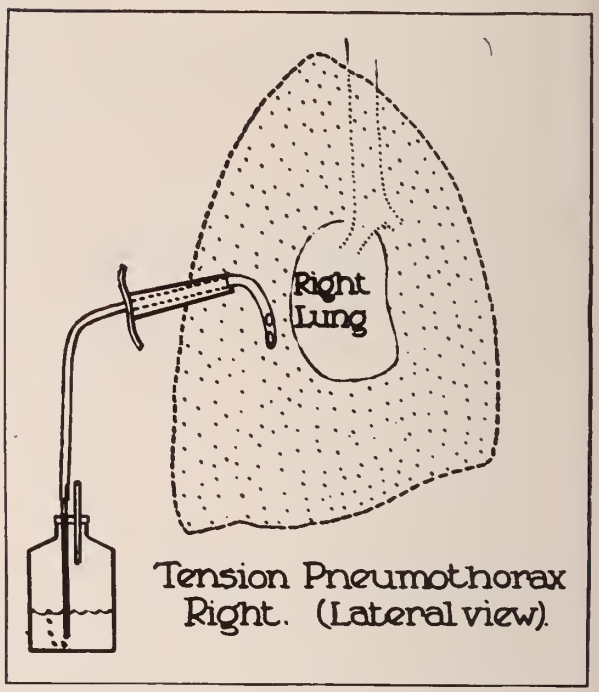

Fig. 4—Treatment of tension pneumothorax by subaqueous decompression through catheter introduced with trocar.

Sucking wounds of the chest wall are rare in civilian practice. They produce not only a tension type of pneumothorax but also mediastinal swing and "pendeluft" (Fig. 5). The effects of such a lesion may be grave but they can be prevented by covering the sucking wound with a thick vaseline gauze dressing and by removing any intrapleural air or blood.

Only a few injuries will require immediate thoracotomy; in those that do, the operation may mean the difference between life and death. The situations which demand heroic surgical measures are wounds of the heart and great vessels, the bronchi, trachea, and esophagus. Cardiac contusion, a common occurrence in patients sustaining thoracic trauma, can be recognized if looked for; while not a surgical condition, it does require special consideration.

Wounds of the diaphragm, with or without rupture, need surgical repair but are usually not acute emergencies. Right diaphragmatic rupture is often associated with liver fracture and the presence of bile and blood in the pleural space. The rent in the diaphragm can be repaired through the thorax, and the liver wound can be drained subdiaphragmatically. Left diaphragm wounds and rupture frequently cause seri-

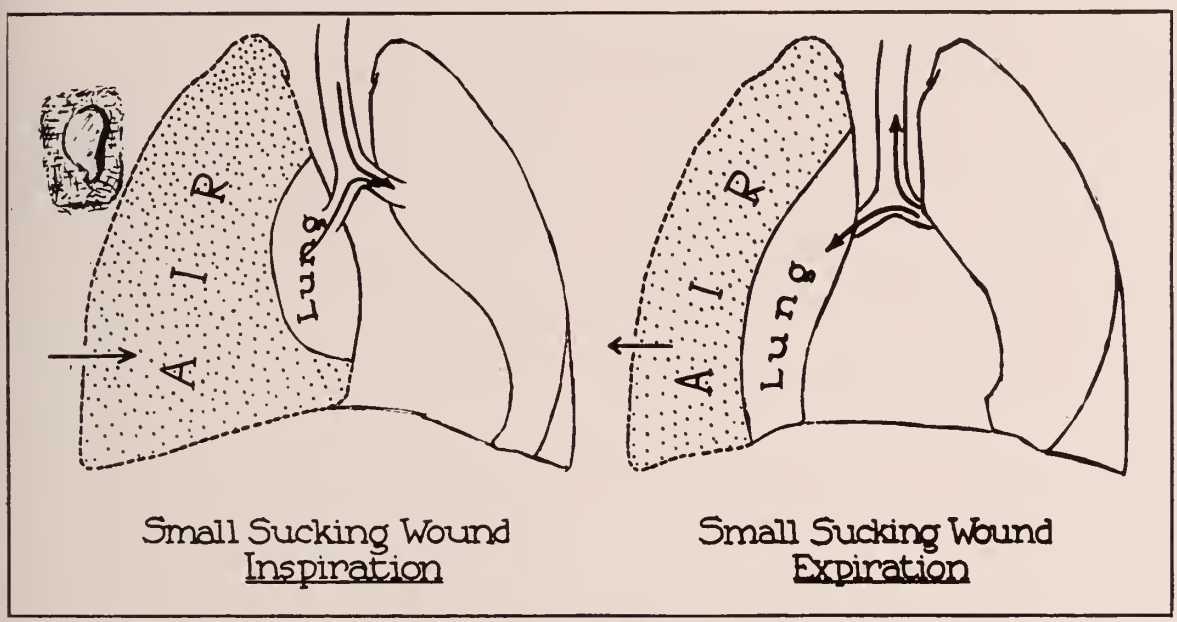

Fig. 5—Effect of small sucking wounds, and treatment with sterile vaseline gauze dressing.

ous complications. These wounds should be corrected as soon as the patient's condition permits.

One type of chest injury which demands special consideration is the severe crushing type, with multiple rib and sternal fractures. Most of the patients have a "flail" chest wall and paradoxical respiration. They are treated according to the principles we have enumerated. I have found that many of these patients can be treated successfully by exercises, reassurance, and intercostal nerve block. In some, the chest wall may have to be stabilized by bandages or adhesive tape, external traction to ribs and sternum, or open fixation. Of most importance in these patients is the maintenance of an open airway. It is in this group that bronchoscopy and repeated endobronchial aspiration may be lifesaving.

324 East Wisconsin Avenue.

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WISCONSIN HEART ASSOCIATION ANNUAL MEETING

The annual meeting of the Wisconsin Heart Association will be held on Saturday, June 4, at the Marquette Union, Milwaukee. Among the guest speakers will be Dr. Herman Blumgart, Harvard University; Dr. W. A. Sodeman, Missouri; Dr. Charles Kossman, New York; and Dr. James Culbertson, Iowa. There will be morning and afternoon scientific sessions and a noon luncheon meeting, with Dr. James Watt, Director of the National Heart Institute, as guest speaker. There is no registration fee, and you need not be a member to attend.

Hemorrhage in Pregnancy*

PART II (CONCLUSION)

Intrapartum and Postpartum Hemorrhage

ALTHOUGH hemorrhage during the first trimester of pregnancy contributed a number of maternal deaths in the cases that have been studied in the Wisconsin Maternal Mortality Survey, the large majority of hemorrhagic fatalities occurred during the last trimester of pregnancy. From the study made to date, it is apparent that intrapartum and postpartum hemorrhage present a major problem in obstetrical practice in Wisconsin. That Wisconsin is not unique in this is revealed by well-conducted maternal mortality surveys in other states,[1] where the same problems in obstetrical care seem to exist.

In the Wisconsin survey, the Study Committee attributed 15 of the 39 maternal deaths to ruptured uteri. This is a high proportion and emphasizes the need for improving the intrapartum and immediate postpartum observation and care of the parturient patient. Except for ruptures occurring in 2 patients who had previous cesarean section scars, the fatalities were generally observed in patients with a high degree of multiparity. The grand multipara is an obstetrical risk and is especially prone to develop complications which will lead to hemorrhagic fatalities if not conservatively managed. Traumatic deliveries brought about by version and extraction following manual dilatation of the cervix were the chief factors accounting for ruptured uteri in the current series. It is felt that manual dilatation of the cervix is a tremendously hazardous procedure and is particularly contraindicated in the presence of placenta praevia. This dilatation is a form of accouchment forcé which is not an acceptable procedure in modern obstetrical care. When it is performed, the risk of irreparable uterine damage, leading to a rapid summation of events and death, is great. The administration of injudicious dosages of pituitrin before or at the time of manual dilatation was also responsible for a fair number of rupture deaths. Version and extraction performed under types of anesthesia which were not sufficient to relax the uterus contributed toward causing ruptured uteri. The indications for this procedure are now very few; but when performed, the operation should be attempted only when the uterus is completely relaxed and preferably with the patient under deep ether anesthesia.

Traumatic lacerations of the vaginal vault, lacerations of the cervix, and bleeding from episiotomy wounds as factors in the causation of bleeding in the immediate postpartum period can usually be recognized without difficulty if adequate inspection is made. Proper visualization of the cervix and vagina should be made and repair instituted before the blood loss becomes a major factor. Immediately after a difficult operative delivery, the physician should inspect completely the vaginal vault and cervix, as well as meticulously explore the lower uterine segment and corpus cavity to discover possible uterine rupture. If traumatized areas are found and repaired early, much valuable time can be saved and the patient can be spared an overwhelming amount of blood loss. Current statistics indicate that, in cases of uterine rupture, earlier diagnosis is necessary. Since signs of shock with pallor, rapid pulse, and drop in blood pressure are confusing in the recently delivered parturient, fatal hemorrhage may be misdiagnosed. In our survey, there were cases in which the Study Committee agreed that the deaths were caused by undiagnosed uterine ruptures, although data on the death certificates indicated that the fatalities were due to coronary thrombosis or pulmonary embolism. Blood replacement is mandatory immediately and should be given in adequate amounts to treat the shock and to prepare the patient for abdominal hysterectomy, which is the treatment of choice in this serious complication.

As is customary in hemorrhage statistics, abruptio placentae was the complication causing death in a few instances. In these cases the abruption was either recognized too late or conservative management was elected. Hemorrhage from premature detachment of the placenta can be dangerously profuse, and delay in treatment may be hazardous. Blood transfusions in this complication are imperative and, again, should be given early and in sufficient amounts. The committee feels that

* Prepared for the Study Committee of the Wisconsin Maternal Mortality Survey by Alice D. Watts, M. D., Milwaukee.

early diagnosis of abruption and abdominal delivery with blood replacement should be the method of choice in the treatment of this highly fatal maternal complication. Incoagulability of the blood due to hypofibrinogenopenia is a serious complication of abruptio placentae and is often fatal. A recent approach to the problem is of interest; treatment of a true afibrinogenemia with fibrinogen is reported to be spectacular. However, physicians should not neglect to institute the necessary treatment of abruptio placentae early, before secondary hemorrhage, with its attending shock and uncontrollable bleeding factors, occurs.

In placenta praevia, diagnosis is again important. A history of painless and recurrent episodes of bleeding often precedes the terminal hemorrhage. Painless bleeding in the last trimester of pregnancy necessitates hospitalization of the patient rather than carrying on conservative management outside the hospital. Examination of the patient in the hospital, with blood obtained in advance, is imperative. If the patient is a multigravida advancing rapidly in active labor and if bleeding can be controlled by amniotomy, vaginal delivery may be safely accomplished. In cases other than this, statistics universally show that placenta praevia is always best treated by cesarean section.

It has been important to know that hemorrhage is the leading cause of maternal deaths in our state. In all instances the members of the committee have had the advantage of looking back on situations which, at the time they occurred, were extremely fulminating and acute. Decisions had to be made, right or wrong, at the time of the emergency; and judgment is often influenced by local conditions and facilities. The committee feels, however, that the situation can be improved and that justification for the effort and time spent on the survey rests chiefly in obtaining the cooperation of the profession in the correction of basic deficiencies.

If we are to find effective answers to the problems which hemorrhage poses, consideration must be given some of the problems prevalent in obstetrical practice. Most of these problems have already been indicated but should perhaps be emphasized again. In solving the problems, the most important step is the development of awareness on the part of attending physicians. The run-of-the-mill obstetrical patient presents no difficulties, but the alert physician is on guard for complications which momentarily might present fatal consequences. Diagnosis of the cause of hemorrhage and early methods of control should be improved. It should be emphasized that accouchement forcé is not an acceptable procedure in modern obstetrical care. Hospital staffs should institute control over the administration of pituitrin, and means should be sought to protect the patient from the injudicious use of this drug. Blood transfusion facilities should be investigated and greatly increased; the study revealed that some communities and hospitals are entirely without the benefit of blood bank facilities. Careful prenatal management is important in the prophylaxis of puerperal hemorrhage. Accurate knowledge of the blood state is important during pregnancy and just before labor; deficiencies can usually be corrected by suitable therapy. It is necessary to gain the cooperation of the patient in seeking and continuing good prenatal care. In all series of maternal deaths the fatalities are more apt to occur in patients who have had inadequate or no prenatal care than in those who have received good prenatal care. This is applicable to fatalities from hemorrhage as well as to those due to the other important and related causes of maternal deaths. Present-day practice emphasizes prevention, and in no field of medicine is this principle so important as in obstetrics.

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1. Longyear, H. W., Ott, H. A., and Sutton, Palmer: Maternal death studies—do they have practical value, Am. J. Obst. & Gynec. 67:1288–1297 (June) 1954.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

What conclusion of a foremost investigator in the drug therapy of hypertension should helpfully guide those who have not already confirmed it by their clinical impressions?

In his unique hypertension clinic at Otago University in Dunedin, New Zealand, F. H. Smirk has been using the antihypertensive drugs under such controlled conditions as I do not believe are to be found in clinics here in America. The practical details of Smirk's method of treating hypertension have been described by him in an article[1] which will repay the reader's careful study.

When a patient enters his clinic, blood pressures are measured by technicians throughout six or seven hours of the day at approximately half-hour intervals for five or six days of the week for three weeks; during this time each dose of the drug that is being studied is adjusted in terms of response to previous dosage. Smirk considers that his method approximates a clinical biologic assay and that through it the patient gains considerable insight into the principles of treatment. After the initial three weeks, the patient attends the hypertensive clinic, weekly at first, and then at longer intervals later. Occasionally, all-day tests are made; but most of the control in the later stage is in terms of hypotensive symptoms. The casual blood pressures taken are considered to be of little help in controlling dosage.

Working under these conditions, Smirk finds that quite high blood pressures may be encountered in outpatients whose blood pressure, under therapy, is satisfactory under home conditions. This latter is the point I wanted to emphasize; namely, that this study under exceptionally favorable circumstances has convinced the experienced and very astute man who performed it that the blood pressure recorded in the office or clinic does not accurately represent the pressure with which the patient is pursuing his daily life.

Smirk's advice, based on this observation, is very logical; adjust dosage of antihypertensive drugs on the basis of reported hypotension symptoms rather than on the basis of the blood pressure readings of the physician after the preliminary period of dosage determination is passed.

What astonishingly versatile drug was added to our armamentarium during the past year, and what are its toxic proclivities?

Chlorpromazine has not only been found effective as a synergizer or potentiator of the action of narcotics, analgesics, hypnotics, anesthetics, and muscle relaxants, and as an antiemetic in the treatment of nausea and vomiting from various causes, but has also proved useful to control withdrawal symptoms in chronic alcoholics and as an inhibiting agent in psychomotor excitement and manic states.

The following list of side effects of this drug can be assembled from the literature: dryness of mouth; sedation and drowsiness; transient postural hypotension, palpitation, tachycardia, and flushing of face; emotionally intense and vivid dreams. One also hears of nasal congestion, myosis or mydriasis, constipation, and mild fever, as well as hypothermia, being encountered at times. There seems to be a variable effect on cardiac output and no evidence of renal toxicity or of difference in effect in patients with or without renal impairment. I believe the jaundice noted in the report of H. E. Lehmann and G. E. Hanrahan of Montreal[2] has been found in other studies to reflect bile stasis rather than damage to the liver parenchyma.

I have not read or heard of reactions of a serious nature to chlorpromazine, but it is certainly important to be aware of the possibility of such occurrences. As of this moment, the drug is very attractive; and I think it likely that much more, in the main

of a quite pleasing nature, will be heard about it in the next few years. It has already acquired trade names throughout the world: Thorazine in the United States; Largactil in Canada, England, France, and Italy; Megaphen in Germany; Ampliactil in Argentina; Amplictil in Brazil; and Hibernal in Sweden. —HARRY BECKMAN, M. D.

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2. Lehmann, H. E., and Hanrahan, G. E.: Chlorpromazine; new inhibiting agent for psychomotor excitement and manic states, A.M.A. Arch. Neurol. & Psychiat. 71:227–237 (Feb.) 1954.

ARE YOU USING THESE GUIDES?

The divisions, committees, and councils of the State Medical Society of Wisconsin, in cooperation with various voluntary and governmental agencies, have been responsible for the development of numerous guides and manuals related to certain aspects of medical practice. While these have been made available to every member, it is quite possible they may not be at hand when the occasion arises for their use.

The following guides and manuals are available upon request to the State Medical Society office:

1. **Adoption Procedures in Wisconsin**—A reminder of statutes governing adoption proceedings and a guide to agencies serving the unwed mother or married parents seeking to place a child for adoption.
2. **Civil Defense Manual for Mobile Medical Team Personnel**—An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.
3. **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.
4. **Ethical Practices in Reference to Workmen's Compensation and the "Open Panel Program"**—A guide for the use of physicians, industrial nurses, management and insurance carriers in handling consultation, reports, complaints, and free choice of physician in relation to the compensation program.
5. **Guide for the Development of a Local or Regional Rheumatic Fever Program**—Recommendations for a model plan of rheumatic fever program emphasizing the convalescent home, diagnostic and follow-up clinics, and a home-service program.
6. **Hearing Conservation Programs for Wisconsin Industries**—Some recommended standards and principles for providing a hearing conservation program in industry.
7. **Industrial Health, A Guide for Medical and Nursing Personnel**—General principles and suggested procedures for an industrial health program, especially in relation to standing orders for nurses.
8. **Medical Care of Migrant Agricultural Workers**—A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.
9. **Membership Manual of the State Medical Society of Wisconsin**—A manual on membership and dues problems of the State Medical Society and the American Medical Association. Primarily for the assistance of county medical society officers.
10. **Minimum Standards of Medical Care for County Hospitals**—A guide to physicians and county asylum superintendents concerning medical care for patients in county hospitals.
11. **Participation by Physicians in Radio and Television Programs**—A guide to physicians and county medical societies for their presentation of or participation in radio and television programs.
12. **Planning Your Career as a Medical Associate**—A brochure to acquaint young people with the careers open to them in fields related to medicine.
13. **School Health Examinations**—A guide for physicians and school authorities in establishing a program of school health examinations.
14. **School Vision Screening Program**—An outline to facilitate the development of a program to detect significant visual defects among school children.
15. **Standards for Management Services Desiring to Advertise in the Wisconsin Medical Journal**—A list of standards under which the Wisconsin Medical Journal will accept advertising on behalf of management services for physicians.
16. **Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers**—A list of the objectives of the State Medical Society in devising the Wisconsin Plan and the conditions under which insurance carriers may participate in that plan.
17. **Wisconsin Physicians Service Manual**—A guide for physicians and their office assistants in servicing contracts held by subscribers to the Blue Shield Plan of the State Medical Society of Wisconsin.
18. **Wisconsin Veterans Medical Service Agency Schedule of Fees**—A description of the Wisconsin Veterans Medical Service Agency of the State Medical Society, instructions on arranging "home-town" care for veterans with service-connected disabilities, and the schedule of fees negotiated with the Veterans Administration.

Venereal Disease Is Still With Us

As It Looks to Your State Board of Health

SYPHILIS and gonorrhea are old, very common, and serious diseases of mankind. The onset of either disease can be so mild or hidden that it frequently escapes significant detection by patient and doctor; detection of early syphilis is the exception, not the rule. The undiagnosed cases are responsible for the reservoir of infection propagating the diseases and for the pathologic residuals of late disease. The complications and sequelae of these diseases can be very serious. In the distant past those from syphilis altered the history and socio-economic status of entire nations. In recent times, society and the medical profession have been cognizant of them for their prominence as causes of insanity, paralysis, blindness, cardiovascular disease, crippling illness, sterility, stillborn infants, congenital defects, and death.

Modern medical effort to control syphilis began with the diagnostic and case-finding blood test of Wassermann in 1907 and Ehrlich's announcement of curative salvarsan in 1910. Thereafter, the practice of blood testing patients, contacts, sources of cases, and apparently well groups to find and bring syphilis to treatment became accepted control procedure by physicians and health agencies. However, the limited application of the practice allowed the prevalence of venereal disease to remain high. In 1937, under the leadership of Dr. Thomas Parran, a nation-wide control program which received financial assistance from federal, state, and local sources was started. It was strongly augmented in 1943, when there were reports on the effectiveness of penicillin in therapy. The success and merit of the program is reflected in the following occurrences in the United States:

A. A threefold decline in syphilis mortality rates and first admissions to mental hospitals between 1939 and 1952.

B. A twenty-eightfold decline in infant mortality due to syphilis between 1939 and 1952.

C. A twofold decline in reported congenital syphilis, from 17,600 in 1941 to 8,021 in 1953.

D. A precipitous drop in reported syphilis cases from the highs of 485,560 in 1941 and 575,593 in 1943 to 156,099 in 1953.

Unfortunately, as the first skirmishes against syphilis appeared won, a sense of false security developed, even among physicians; and in 1950 Congress began drastic cuts in the funds necessary to sustain the essential activities of the program. This dubious economy move was also prompted by the misconception that penicillin with its excellent treatment effects would somehow possess equal case-finding magic. Epidemiologists are aware that the propagation of venereal diseases is sustained by the reservoir of infectious undiagnosed cases. Treatment is essential to the diagnosed case but cannot affect the undiagnosed reservoir or rate of spread therefrom.

As a result of premature de-emphasis, 34 state health departments now consider their venereal disease funds insufficient to permit effective case-finding and to insure a continual fall in rates. Supporting their belief is the fact that during 1954, 20 states experienced a rise in reported syphilis rates and 36 a rise in gonorrhea. Preliminary evidence suggests increases in additional states during 1955.

New cases of venereal diseases ranked high among other diseases reported to the National Office of Vital Statistics in 1953—measles, 449,146; gonorrhea, 246,311; syphilis, 150,026; scarlet fever and strep throat, 132,935; tuberculosis, 106,925; pertussis, 37,129; acute poliomyelitis, 35,592. By age distribution early syphilis and gonorrhea rates rise abruptly in the 15 to 19 age group, reach a peak in the 20 to 24 age group, and fall sharply back by age 35. Early latent syphilis rates are three times the primary and secondary stage rates, even in the 15 to 19 age group, again emphasizing that primary and secondary syphilis commonly remain undiagnosed and require active case-finding for disclosure. Reporting of gonor-

rhea is very incomplete, the true incidence being four to five times the number of cases reported. Some doctors are treating gonorrhea without "officially" diagnosing it, thus sparing the patient from the disease label plus questions on source and contacts. This does not serve the interest of disease control nor the welfare of patients who have concurrently acquired an incipient syphilis infection that remains masked by such treatment.

In Wisconsin the major portion of venereal disease control funds has vanished, and complacency exists as elsewhere. The prevalence of gonorrhea is high, and reported syphilis shows an increase—1,251 cases in 1954 compared to 1,091 cases in 1953. However, the practical elimination of venereal disease is within reach of Wisconsin doctors and can be achieved as rapidly as their collective interest and effort mount. Where existing, the optimistic belief that penicillin alone can erase venereal diseases needs to be dispelled. Case-finding and case-holding activities must be the duty of all who undertake the responsibility of managing venereal disease. The doctor who treats cases and investigates source and contacts, or refers them to the health department, promptly contributes to better control. The doctor who treats cases but neglects source and contacts breaks no significant link in the chain of infection and does a disservice to the individuals harboring unknown disease.—A. L. VAN DUSER, M. D., *Director, Division of Venereal Disease Control.*

SYMPOSIUM ON OFFICE PROCEDURES AND CLINICAL MEDICINE

Madison, Wisconsin, Friday, June 24, 1955

At New East Side Business Men's Club on Lake Monona

Under the joint auspices of the Wisconsin Academy of General Practice and Lederle Laboratories Educational Services.

All physicians and their wives invited.

Time—10 a.m. to 5 p.m.

Luncheon for doctors and wives. Special program of entertainment for the ladies.

Cocktails—5 to 6 p.m.

PROGRAM

A. M.
10:00–10:40—"Management of Fractures of Extremities about the Joints," Paul Pemberton, M. D., Associate Professor of Surgery, University of Utah, Salt Lake City
10:40–11:20—"Diagnosis of Poliomyelitis," Alex J. Steigman, M. D., Professor of Child Health, University of Louisville, Louisville, Kentucky
11:20–12:00—"Common Anorectal Disorders, Their Pathogenesis, Diagnosis, and Treatment," J. P. Nesselrod, M. D., Associate in Surgery, Northwestern University, Evanston

P. M.
12:00–12:30—Questions and panel discussion
12:45– 2:15—Luncheon for physicians and their wives
2:30– 3:10—"Office Management of Allergies," George I. Blumstein, M. D., Assistant Professor of Medicine, Temple University, Philadelphia
3:10– 3:50—"Management of the Oliguric Patient," Lewis W. Bluemle, M. D., Associate in Medicine, University of Pennsylvania, Philadelphia
3:50– 4:05—Recess
4:05– 4:45—"Infertility," Christopher Duncan, M. D., Clinical Associate in Gynecology, Harvard University, Boston
4:45– 5:15—Questions and panel discussion

Six hours formal credit for Academy of General Practice members.

For ladies' reservations write: Mrs. R. F. Collins, 941 Harvey Terrace, Madison, Wisconsin.

For hotel and housing write: J. Kent Tweeten, M. D., 520 South Park Street, Madison, Wisconsin.

Clinicopathologic Conference

Sponsored by the Section on Pathology, State of Wisconsin Medical Society
Guest Editor: John Lunseth, M. D.

REPORT OF A CASE*

A 26-year-old, colored female was admitted to Milwaukee County General Hospital on August 28, 1953, complaining of fatigue, a rash on the right side of the face, and weight loss. The patient had apparently been well until three years prior to admission. At this time she experienced loss of appetite and progressive weight loss. She had lost a total of 90 pounds at the time of admission. A progressive feeling of fatigue had accompanied this complaint. She noted shortness of breath on exertion six months prior to entering the hospital, a drooping of the right side of the face for the six months previous to entry, and a swelling and a rash on the right side of the face for two weeks before entry.

A system review showed occasional headaches over the right eye relieved by salicylates, and bad tonsils which had been swollen from time to time over a period of many years. A chronic cough of about nine months' duration was present; this cough was productive of one-half cup of "dry, gummy" sputum which was white and did not contain blood. The menarche had occurred when the patient was 10 years of age; and periods were irregular, lasting from six to eight days, with a heavy flow. The flow had become scanty in the three months prior to admission. Urgency and frequency had been present without nocturia, incontinence, or burning for an unknown period of time. The patient was a gravida IX, para VII. Neither the social history nor the family history was contributory.

Physical examination revealed a well-developed but poorly nourished, colored female in no distress. She was alert and cooperative. Her weight was 125 pounds, blood pressure 106/86, respirations 20 per minute, pulse rate 88 per minute. Examination of the head showed an asymmetry of the face with some swelling of the right cheek and maculosquamous lesions approximately 1 cm. in diameter distributed over the right cheek. There was ptosis of the right lid and miosis of the right pupil. No distinct enophthalmos could be noted. The tongue was slightly enlarged and had a brownish coat with prominent papillae. The tonsils were enlarged, and nodes were palpable in the anterior cervical chain. These nodes were small, soft, discrete, and nontender. Axillary and inguinal adenopathy were present. The chest showed questionable limitation of expansion on the left but was clear to percussion and auscultation. The heart was not enlarged and was regular; sounds were of good quality. No murmurs were heard. Examination of the abdomen showed the liver, kidney, and spleen to be not palpable. However, there were two golf-ball-sized, mobile, nontender masses in the epigastrium; they

Urinalysis

Specific gravity	1.016
Reaction	Acid
Albumin	0
Sugar	0
Red blood cells	1–2
White blood cells	12–14
Calcium	11.9
Phosphorus	5

The Kline test was negative. (Two weeks later, Kline test 2+)

Blood

Red blood cells	5,010,000
Hemoglobin	12.5 Gm.
Color index	0.8
White blood cells	8,500
Stabs	28
Segs	32
Lymphocytes	29
Monocytes	4
Eosinophils	7
Platelets	Plentiful
Total protein	9.1
Albumin	3.3
Globulin	5.8
Alkaline phosphatase	7.9
Prothrombin time	53.5 per cent
Cephalin cholesterol flocculation	3+/48 hours
Thymol turbidity	9 units
Sedimentation rate	57 mm./1 hr.

LE preparation showed no LE cells present

First strength Mantoux, negative
Second strength Mantoux, 2+

The patient had a daily fever up to 99.8 F. occurring in the afternoon or late afternoon.

Films of the skull and films of the right mandible were reported as normal.

Films of the chest showed extensive fibrotic changes in both apices with marked upward retraction in both hilar regions and marked upward displacement of the right transverse fissure. The heart was normal in size, and the pulmonary fields were otherwise normal except for moderate emphysematous changes.

Films of the abdomen showed no pathology.

Seven days after the patient's admission, a biopsy of the right axillary node was performed.

* From Milwaukee County General Hospital.

did not appear to move on respiration. There were no remarkable findings on pelvic examination except for a retroflexed uterus. The rectal tone was good. No masses were felt, and brown feces were present. Neurological examination showed a slight right facial weakness and anhidrosis over the right side of the face.

It was the impression that the patient had lymphosarcoma with skin infiltrations and a right incomplete Horner's syndrome.

Dr. E. G. Olmstead: I shall ask Doctor Marks to present the films before we have the discussion.

Dr. J. L. Marks: This was the original chest film that was taken on January 17, 1953; on this film there is a marked retraction of the right hilar structure cephalically and a similar retraction of the left hilar structure to a cephalic position. The transverse fissure, which normally should be at the approximate level of the fourth rib anteriorly, reveals a definite upward retraction. Upward displacement of the transverse fissure, which delineates the basal portion of the right upper lobe, is usually an indication of either collapse of the right upper lobe or retraction of the fissure secondary to fibrosis of the right upper lobe. In this particular case, I feel that the transverse fissure has been elevated secondary to fibrosis of the right upper lobe, with retraction of that fissure. The irregularity of the cardiac borders can be explained on the basis of a mediastinal pleuritis with extensive pleuropericardial adhesions present, secondary to the previous pleuritis in association with the inflammatory involvement. There is no evidence of erosion or destruction of any of the ribs. The diaphragms are in their normal positions with slight retraction of the right diaphragm in the cardiohepatic angle region. Subsequent films on this patient revealed no change.

An abdominal film was also taken, as mentioned on the protocol. The liver shadow was visualized and was within normal limits. The kidney structure on the right side was incompletely visualized, but what was visualized appeared normally outlined. The left kidney was not visualized. The masses described in the region of the epigastrium could not be outlined. A normal amount of gas was present in the regions of the stomach and the large bowel. There was no evidence of intestinal obstruction. The splenic shadow was not visualized. It did not appear to be enlarged. Subsequent films again showed the same features present with fibrosis of the right upper lobe and similar fibrosis and infiltration present in the left upper lobe. These were the oblique projections of the patient. They do not offer us any further help.

A Bucky projection revealed no evidence of pulmonary destruction, and no evidence of cavitation could be visualized on the projection. This projection was taken for the purpose of attempting to bring out parenchymal destruction.

The skull films on this patient were within normal limits. The pineal gland is calcified and is within its normal position. The PA skull film shows the pineal gland centrally placed with no evidence of shift to either side of the cranium.

Films of the hands and feet of the patient, probably taken to check on the possibility of sarcoid, show no evidence of the characteristic manifestation present in sarcoid involvement. However, one must remember that osseous manifestations in sarcoidosis are present in only 12 per cent of the cases. Concerning the pulmonary picture, the so-called classical picture of pulmonary sarcoid is bilateral hilar adenopathy. Doctor Rigler of the University of Minnesota some time ago described what is considered to be characteristic of sarcoid. If one draws a line down the vertebral process, the adenopathy in the hilar region is supposed to be equal on both sides. From our experience with a number of sarcoid cases over a period of time, I would say that this is true only in the so-called classical picture. Other articles have described atypical manifestations of pulmonary sarcoid involvement, and it is almost impossible to differentiate between some of these manifestations and those in typical cases. We suggested that this patient should have an acid-fast workup at the time of the examination.

Doctor Olmstead: Thank you very much. We are fortunate today to have Dr. Banyai from Muirdale Sanatorium with us. We should like to have him discuss the case.

Dr. A. L. Banyai: This patient was ill for about three years, during which time she lost 90 pounds in weight. It is also reported that she had expectoration of about one-half cup of sputum during a 24-hour period. In

addition, we are dealing here with a patient who belongs to the colored race. Progressive loss of weight, persistent cough, and expectoration of half a cup of sputum daily would postulate sputum positive for tubercle bacilli. In my experience I have not seen any Negro person who was ill with active pulmonary tuberculosis and who lost as much as 90 pounds in weight during a three-year period who did not have a sputum positive for tubercle bacilli. In this instance, however, there is a report that no tubercle bacilli were found. I am willing to go on record that most likely this is not a case of pulmonary tuberculosis. Maybe I'm wrong; I have been wrong many times. He who claims that he has never made a diagnostic mistake either has a short memory or is a liar.

What are the other possibilities? The main feature of the x-ray findings, of course, is a pulmonary involvement with a certain amount of fibrosis; and it is very true that here we do not see a typical manifestation of sarcoidosis. As a matter of fact, we do not see typical x-ray manifestations of anything. Pulmonary fibrosis of this sort—bilateral fibrosis with more involvement on the right side—may result from a great many causes. It may result from a number of infections, including infection with the Friedländer bacillus. However, as you recall, Friedländer's infection is a stormy affair. At one time it carried a mortality rate of about 40 per cent or even higher. But I have seen patients that recovered from Friedländer's infection with a more or less pronounced fibrosis, even with so-called sterile cavitation in the lung parenchyma. I do not believe that this person had a Friedländer's infection and recovered from that condition. I believe that she had some illness which lasted throughout a three-year period. There are conditions which may last this long and debilitate the patient, as happened in this case. One could think of some of the collagen diseases, or the condition that was described at Johns Hopkins Hospital some years ago, both in acute and chronic form, as idiopathic pulmonary fibrosis. Hamman and Rich were the ones who first reported this disease. I do not believe that this case showed the characteristics of so-called idiopathic pulmonary fibrosis because the most prominent symptom of that condition is a pronounced and progressive dyspnea, and here that symptom was not as marked as one could anticipate. So we should look for other possible causes which are obscure.

Pulmonary adenomatosis should be taken into consideration. Allegedly, the most characteristic feature of the disease is massive, soapsuds-like expectoration. We have no such symptom in this case. However, I have seen cases of pulmonary adenomatosis without that type of expectoration. I would not consider massive expectoration of soapsuds-like sputum as pathognomonic of pulmonary adenomatosis because, as you know, patients may also expectorate that type of sputum in a number of other conditions. However, following the general way of diagnostic reasoning, perhaps one can say that because this so-called pathognomonic symptom is absent, we should not call this condition pulmonary adenomatosis.

It was stated earlier that perhaps this patient had lymphosarcoma with skin infiltration. The definition of lymphosarcoma needs clarification, and I hope Doctor Lunseth will be kind enough to give us a little postgraduate education. In many textbooks concerning this subject, one can find all kinds of definitions. The last one which I have enjoyed reading is in the classical work of Doctor Willis of England, who has written one of the most outstanding publications in this particular field. Lymphosarcoma is one of the lymphomatoid diseases, and Hodgkin's disease is, of course, included in this group. I have been puzzled in my clinical experience many times by Hodgkin's disease. It is a condition that may simulate many other diseases, including typhoid fever. Some of these patients have what is known as the Pel–Ebstein fever. It is a cyclical elevation of temperature which lasts for approximately a week or 10 days, subsides, and then is followed by another similar episode. Hodgkin's disease may involve the lung; as a matter of fact, it is estimated that in more than one-third of instances of the disease, we find pulmonary involvement in one form or another. Of course, if a lymph node is enlarged, that should be taken out. The largest node should be removed because the daughter lymph nodes may not show the disease. On histological examination, one finds typical Sternberg or Dorothy Reed cells. I do not know why they are called Dorothy Reed or Sternberg cells; there was another physician, Greenberg, who discovered the same cells 20 years earlier. I would be interested to know

whether we are dealing with a case of Hodgkin's disease in this instance, although it doesn't impress me as being one.

One could think of one of the diseases of the hemopoietic system. Some years ago I was asked to look at a patient with a very puzzling problem. He had cough, expectoration, and pulmonary hemorrhage. Postmortem examination confirmed the diagnosis I made; namely, lymphatic leukemia involving the lung. I do not think, however, that here we are dealing with lymphatic leukemia; the report does not show it, and so we had best orient ourselves in another direction.

We often forget that there is such a condition as pulmonary syphilis. Not so long ago we had a patient who was referred to our institution with miliary tuberculosis. As you know, syphilis may appear in the lung in the form of a gumma as big as an orange or as miliary gummata as small as pinheads scattered all over the lung. It may result in pulmonary fibrosis or may appear in the form of a classical Ayerza's disease. The abovementioned patient came in with a tentative diagnosis of miliary tuberculosis. As you know, patients with miliary tuberculosis are very ill. This patient was not very ill and had very little elevation of temperature; the only proof of miliary tuberculosis she had was miliary nodules in both lungs. We cured this "miliary tuberculosis" by 7,000,000 units of penicillin since it was not miliary tuberculosis but miliary gummata of the lung. Many syphilitic infections heal spontaneously. When syphilis heals, it may do so by fibrosis. I wondered when I checked the laboratory report if there was anything indicating that this person had syphilis. She would have shown positive serologic reactions on repeated occasions as far as syphilis was concerned. However, she was serologically negative for syphilis; and in view of this fact, I would discount the possibility of pulmonary syphilis.

Lupus erythematosus can be excluded; and, of course, we can rule out occupational fibrosis for the reason that the fibrosis in this instance is not evenly distributed in the lung as it usually is in occupational forms of fibrosis such as silicosis, silicatosis, and asbestosis. Also, we might consider berylliosis; but the case does not look like it and there is no occupational history, so I am prepared to discard the possibility of industrial pulmonary fibrosis.

There was one disease mentioned here by Doctor Marks which I believe we should discuss seriously, and that is sarcoidosis. This is often called Boeck's sarcoid, although it was identified 20 years earlier by Besnier and by the famous Hutchinson, who described the syphilitic triad, observed 40 years before Boeck. Schaumann called it benign lymphogranulomatosis. This is a good term which gives an appropriate connotation of the disease. If we would like to call this condition by any eponym, we should call it the Hutchinson–Besnier–Boeck–Schaumann syndrome. Osler once said "know syphilis and the whole of medicine is opened unto you." I can paraphrase Osler and say that, if you know sarcoidosis, you know internal medicine, for the simple reason that there is no organ in the body which cannot be involved by this particular disease.

Sarcoidosis is a mysterious disease. We know so much about it; its histology is so accurately described, and it has been known to clinicians and pathologists since 1867 when Hutchinson first reported it. Yet we still do not know positively its etiology. I take the stand that sarcoidosis is caused by an attenuated form of the tubercle bacillus. This condition may be seen in the lung in the form of miliary nodules, in the form of a bronchopneumonia-like lesion, or as a lobar involvement. It may develop in the hilar and paratracheal lymph nodes, and then it appears in the form of so-called "potato" nodes, which are greatly enlarged lymph nodes. If you find lymph nodes of that size and that kind, you will note that they really look like Irish potatoes. There is no such thing in sarcoidosis as a symmetrical enlargement of mediastinal lymph nodes. As a matter of fact, I would like to emphasize their asymmetry. Patients with sarcoidosis may develop Ayerza's disease. On the other hand, sarcoid lesion of the lung may disappear without any aid whatsoever. Disaster occurs when sarcoidosis heals by fibrosis or when the patient develops active tuberculosis. The latter happens in almost 60 per cent of patients who reach a hospital. When the sarcoidosis heals by fibrosis, then a difficult situation will arise, because if fibrosis in the lungs is very extensive, cor pulmonale will develop and the patient will die of it. Another possibility is that the patient may die from involvement of the heart muscle or the hemopoietic system. I have also seen patients with

(Continued on page 268)

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(Continued from page 265)

sarcoidosis die after splenectomy done for the treatment of what appeared to be essential thrombocytopenic purpura.

There is some possibility that, in spite of the negative findings, this patient had sarcoidosis. The great loss of weight may be due to involvement of the central nervous system. As far as this case is concerned, my preference is to consider it sarcoidosis, with either a central nervous system or perhaps an abdominal involvement, something more serious than merely the pulmonary disease. I would take a wild guess and say that perhaps there was some myocardial disease caused by sarcoidosis. There are a few suggestive items in the record. I notice that there is a reversal of the albumin-globulin ratio, an increased calcium content, and some eosinophilia. All of these things occur in sarcoidosis, although none of them are pathognomonic of sarcoidosis. I am not here to enumerate how many other conditions, including Hodgkin's disease, may be associated with reversal of the albumin-globulin ratio. Multiple myeloma, alcoholic cirrhosis of the liver, and lupus erythematosus are some of these conditions. But we do know that reversal of this ratio occurs in sarcoidosis, and it is a very interesting thing to speculate why there is this albumin-globulin ratio reversal. My opinion is that this reversal is due to a hyperimmune state. These patients become highly immune against the tubercle bacilli, until their immunity is exhausted. Then tuberculosis will ensue. When one examines some of the specimens histologically, he finds changes that look like amyloid around the sarcoid nodules. They are designated as paramyloid; and that, I believe, supports my contention that the reversal of the albumin-globulin ratio is primarily attributable to a hyperimmune state. In horses that are used for serum production following the injection of diphtheria vaccine, amyloidosis will develop if such injections are carried out too long. The immune response of the animal is exhausted; and by a union of the antigen injected and the defense compounds produced by the body, there develops a substance which we recognize as amyloid. Paramyloid is a very similar substance, and it is very strongly suggestive of the possibility that sarcoidosis is a hyperimmune condition. Incidentally, in many instances the tuberculin reaction of the skin is negative. It is negative because the body of a sarcoid patient contains an oversupply of immune bodies which are capable of neutralizing the tuberculin. So, putting all of these things together, I would be willing to risk a tentative diagnosis of sarcoidosis, with death from an unknown cause. I suspect that the patient might have had either a central nervous system or a cardiac condition. As you know, sarcoidosis is far more common in the Negro than in the white race. I do not know why, but this has been my experience and a number of reports in the literature confirm this point.

Doctor Olmstead: Thank you very much, Doctor Banyai. Does anyone have any questions or is there any further discussion on this case?

Dr. B. A. Waisbren. First, I am very happy that you had Doctor Banyai here. I hope we can have him back at more of these meetings. I have several questions I should like to ask him. First, whether he has ever seen empyema in sarcoidosis. I would also like to know about the epidemiology, or differences within the country, of atypical tubercle bacilli. As you know, in some of the recent studies, an epidemiologic attempt to find out the etiology of sarcoidosis has shown that, in some sections of the country, particularly in the southeast portion, there is a greater incidence of the disease. The increased incidence here is greater than the increase that might be attributed to the concentration of colored people in that area. I wondered if there have been any epidemiologic studies of the differences in tubercle bacilli in those areas in relation to the tuberculous etiology of sarcoid.

Another study that has come out within the last three months is by Israel. In this study he showed that patients with sarcoidosis have inability to get delayed reactions to all antigens, or to any antigen, that gives a delayed type of skin sensitivity reaction, and I would like Doctor Banyai to comment on that. Does he think that there is an inability of these people to react to other skin antigens? Finally, I wonder how he feels about the work of Rosenthal, who has taken lymph nodes from people who have sarcoid, put them in guinea pigs, and found that there was a positive tuberculin test later on. That, I believe, is probably the best evidence that I have found on the concept that sarcoidosis is a form of tuberculosis.

Doctor Olmstead: Perhaps we can have the pathological findings, and then Doctor Banyai can answer any questions that are asked him.

Dr. John Lunseth: The autopsy was limited to the chest. However, we got a few specimens below the diaphragm—portions of the spleen, mesenteric lymph nodes, and liver. All the lymph nodes we examined, the spleen, and the liver showed involvement by the granulomatous process. The greatest lymph node involvement was in the anterior cervical region. There were enlarged involved lymph nodes below the sternum and over the thymus. However, they did not emanate from the latter. There was some attachment of the involved nodes to the periosteum and to the sternum, and there was also extension of the granulomas into the inner surface of the right anterolateral wall of the pericardium and over the epicardium beneath that point. Both pleural cavities were almost completely obliterated by adhesions caused by the granulomas in the visceral pleura being attached to the parietal pleura. This obliteration was especially dense in the right apex, and there was extension of the granulomas through the visceral pleura of the apex into the overlying connective tissue. This involvement probably explained the Horner's syndrome mentioned in the clinical history.

In the first slide is seen grossly a cross section of several tracheobronchial lymph nodes. They are greatly enlarged and have a resemblance to a sectioned Irish potato.

The next slide is a photomicrograph of a tracheobronchial lymph node, showing the mosaic pattern of the involved lymph nodes. This is caused by the fact that the lesions, although very close together, are quite discrete.

In the next slide is seen a high-power view of a lymph node, showing paramyloid deposition in and around the nodules.

In the next photomicrograph, there is a lymph node stained with a connective tissue stain showing an individual nodule. In the center of the nodule the epithelioid cells are plump and loosely arranged, whereas at the periphery the cells became more compressed and thereby more fusiform. Also, at the periphery, the reticulum fibers appear to have consolidated into collagen. Perhaps this compression of the peripheral components of the nodule into a sort of pseudocapsule accounts for their discreteness.

The next slides are gross photographs of the cross section of the right lung, showing extensive fibrosis and considerable involvement of the visceral pleura and small cystic areas between the granulomatous nodules and areas of fibrosis. Also seen in one of the photographs is a partly calcified caseous area in a tracheobronchial lymph node.

We also have photomicrographs of the lung showing how the granulomas developed and produced the extensive deformity of the lung. In one slide, we see a rather young granuloma arising from the interalveolar septum.

Other slides show the following things:

- Several coalesced granulomas surrounding a small pulmonary artery and causing some sclerosis
- A granuloma developing from the intima of a vein
- A granuloma arising from the wall of a bronchiole and extending outward, producing retraction so that the bronchiole is dilated
- Several well-developed granulomas arising from the alveolar septa and coalescing to form a large granuloma undergoing early fibrosis.
- A large area of fibrosis in the midst of the alveoli. It is composed of coalesced granulomas undergoing extensive fibrosis.
- A small cyst caused by retraction of the walls of the bronchioles and alveolar ducts by a surrounding, fibrosing, granulomatous process.

The preceding photomicrographs of the lung have shown that the granulomas of Boeck's sarcoid arise from the alveolar walls, from around the blood vessels, and from around the branches of the bronchial tree. It can be seen that these granulomas coalesce, undergo fibrosis, and destroy functioning lung tissue. The cysts, it would seem, result from a retraction of bronchial and alveolar walls when the granulomas fibrose. The cysts thus formed are epithelized by bronchoepithelium. This epithelialization explains the shiny gross appearances of the cyst lining.

We have a photomicrograph showing a Schaumann's crystal in a giant cell. These crystals are quite characteristic but are not pathognomonic of sarcoid.

The next slide is a photomicrograph of the parietal pericardium showing involvement by Boeck's sarcoid.

Our last three slides show fibrosing granulomas extending from the visceral pericardium into the myocardium; a high-power view of the accompanying destruction of myocardial fibers; and a section of a sarcoid granuloma in the portal triad of the liver.

In summary, then, this is a case of Boeck's sarcoid involving the lungs; the tracheobronchial, cervical, mesenteric, and retroperitoneal lymph nodes; the liver; the spleen; the pericardium; and the myocardium. The extensive involvement of the lungs probably produced a severe respiratory insufficiency, which evidently played a very important part in the actual cause of death. Perhaps the involvement of the myocardium might also have been a factor in the patient's death. The Horner's syndrome can be explained by the involvement of the right apical pleura. Despite the change of the Mantoux from negative to positive, no evidence of active tuberculosis was demonstrated.

The main anatomical diagnoses are generalized Boeck's sarcoid of the lymph nodes, of the pericardium, the myocardium, pleura, lungs, spleen, and liver.

FIFTH COUNCILOR DISTRICT ANNUAL MEETING

Thursday, June 23, 2:00 p.m., Hotel Hamilton, Two Rivers

PROGRAM

P.M.

2:00–2:40 What's New in Medicine—Nathan Smith Davis, M. D., Department of Medicine, Northwestern University Medical School, Chicago

2:40–3:20 What's New in Surgery—Earl O. Latimer, M. D., Department of Surgery, Northwestern University Medical School

3:20–4:00 What's New in Obstetrics and Gynecology—Ronald R. Greene, M. D., Department of Obstetrics and Gynecology, Northwestern Medical School

4:00–4:10 Intermission

4:10–5:00 Question-and-answer period

5:30–6:30 Cocktail Hour

7:00–8:00 Banquet

8:00–9:00 Post-Banquet Program

a. Welcoming Address—Hon. John Dever, City Manager, Two Rivers
b. Introduction of officers, speakers, and distinguished guests
c. Address by A. H. Heidner, M. D., West Bend, Councilor, Fifth District
d. Address by Arthur J. McCarey, M. D., Green Bay, Immediate Past-President, State Medical Society
e. Address by E. L. Bernhart, M. D., Milwaukee, President, State Medical Society
f. District transactions
g. Entertainment by Mr. Charlie Hanson, TV star

The afternoon program for the ladies will be under the auspices of the Woman's Auxiliary to the Manitowoc County Medical Society. Arrangements have been made for cards and golf.

The charge per person will be $5; per couple, $10. Due to lack of space, reservations have been limited to 150 persons. Admission will be by reservation only. The meeting is also open to those not residing in the councilor district. Reservations with accompanying checks should be mailed to Wallace Marshall, M. D., Secretary, Bank of Two Rivers Building, Two Rivers, by Monday, June 20.

Dr. Ervin L. Bernhart, new president of the State Medical Society, was born in Milwaukee on August 25, 1899. He received his medical degree from Marquette University School of Medicine in 1925 and served his internship at St. Mary's Hospital, Milwaukee.

A general practitioner, Doctor Bernhart also specialized in industrial medicine. He has practiced in Milwaukee since 1925.

Offices which he has held in local and state medical societies include Councilor from the Twelfth District, alternate delegate to the American Medical Association, member of the House of Delegates, and president of the Medical Society of Milwaukee County. He is a past president of the Wisconsin Academy of General Practice, former delegate from the state Academy to the American Academy of General Practice, president of the Midwest Medical Association, and a member of the World Medical Association and the Milwaukee Academy of Medicine. Active in health insurance activities, he has been chairman of the directing board of Surgical Care, chairman of the Public Relations Committee of the Blue Shield Commission, a member of the Board of Directors of the Medical Indemnity Corporation, and a member of the State Society's Commission on Prepaid Plans. Doctor Bernhart is on the staff of St. Mary's Hospital, Milwaukee, where he now serves as chief of staff and member of its executive board.

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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Volume 54 MAY 1955 Number 5

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Organized Confusion

Last December, some 30 Wisconsin physicians were notified by Selective Service that they could expect to be called to active duty about mid-March, 1955. Although all of them had full knowledge of the likelihood of their call to duty, it was obvious that some of them were engaged in pursuits which might not readily be terminated without considerable difficulty, not only to themselves, but to hospitals or communities which they might be serving. Nevertheless, all of these men made rapid preparations for winding up their affairs and going into service on the appointed date.

Just three weeks before the appointed active duty date, a notice was sent out by Selective Service advising hospitals where any of these men might be taking residencies that, "if they were interested," they could apply for a delay because it turned out that the armed forces didn't need as many men as they had anticipated.

This is typical of the hot and cold attitude displayed by Selective Service throughout the past five years. No one challenges the need of the armed forces under present world circumstances for a reasonable number of physicians to maintain the medical establishment of the armed forces. Nor can one be critical of the state and local headquarters of Selective Service. In Wisconsin, at least, there has been the utmost in cooperation between the medical profession and Selective Service with regard to the orderly call-up of physicians; but the vagaries of Selective Service requirements have played havoc with physicians individually, with communities trying to establish or maintain a minimum amount of medical service, and with medical education and research. Quotas established for physician calls to duty are subject to change without notice. Men called to active duty are suddenly informed that they have an opportunity to delay their service if they so desire. Interpretations of rulings vary from state to state. Changes in physical qualifications and a variety of other factors keep young physicians, educators, and researchers in a constant state of confusion.

The physician draft, if it is to be continued, most certainly demands a complete overhaul, either done voluntarily by the Selective Service System itself or as a result of a Congressional investigation. Long-term planning, a necessity for physicians and those responsible for medical education and research, is virtually impossible under the current draft program. Since the physical qualifications for military service of physicians have been lowered to the point where almost no physician can escape military service on these grounds, it would seem that some schedule could be developed by which the physician graduating from medical school could be given a pretty definite idea of the likelihood of his call to duty.

Most certainly, such a schedule would have to make provision for a certain number of physicians being called to duty immediately after completion of their internships. Other groups could be left to go into service after one, two, three, and four years of residency training. Similar arrangements must, of necessity, be made for at least a certain portion of the graduate students in the sciences. Until such a program is designed, it will be impossible for the medical profession to do a responsible job of planning to meet the needs of society for medical service, to say nothing of meeting the dangers posed to the national health and safety because of our failure to provide for medical teachers and researchers.

An Open Letter to John W. Tramburg

Departing Director, State Department of Public Welfare

Dear John:

We of the Wisconsin medical profession, and its staff, extend you our best wishes as you leave the Wisconsin public welfare department to take a similar position in New Jersey. We congratulate New Jersey, for you have demonstrated here rare administrative competence, a warmth of concern, and keen insight into the needs of those among us who have met misfortune. Whatever New Jersey problems may be, under your guidance progress toward their solution will be made.

And while we pass along these encomiums to you, we must express our deep regret that you are leaving your native Wisconsin. In the years you have been administrative head of our department, we have seen much accomplished and much started on the road to accomplishment. Physical facilities have been and are being much improved. There has been an encouraging *esprit de corps* developed, not alone within your staff, but between your staff and those of associated organizations and municipalities. Public assistance administration has become recognized, under your leadership, as something more than a welfare problem. It has become a matter of concern to all our citizenry—not as something to be met with the minimum of time, money, and facilities, but as a matter deserving the challenging attention of great minds and meriting the service of all who can contribute.

While your time and thoughts must be committed to New Jersey, we know we can look to you for advice and assistance; and while you serve elsewhere, you still serve in carrying out one of man's greatest responsibilities—his love and care of his less fortunate fellow men.

Good luck, John, and with our thanks, also our assurance of welcome to your successor, W. J. Schmidt.

The State Medical Society of Wisconsin

SUMMER CAMP FOR DIABETIC CHILDREN AT LAKE GENEVA

For the seventh season, a summer camp for diabetic children will be opened at Holiday Home, Lake Geneva, Wisconsin, from July 17 to August 7, under the auspices of The Chicago Diabetes Association, Inc.

In addition to the regular personnel of the camp, there will be a staff of resident physicians and dieticians trained in the care of diabetic children. This staff is furnished by The Chicago Diabetes Association.

Boys and girls from eight through fourteen years of age are eligible. For further information regarding fees, write or phone the office of The Chicago Diabetes Association. Fees will be set on a sliding scale to meet individual circumstances.

Physicians are requested to notify parents of diabetic children and to supply the names of children who would like to attend camp. Applications may be obtained from, and inquiries should be addressed to:

The Chicago Diabetes Association
5 South Wabash Avenue
Chicago 3, Illinois
Andover 3–1861

Limited capacity requires prompt application.

Minutes of the Council Meeting, Milwaukee February 26-27, 1955

1. Call to Order

The Council was called to order by Chairman Arveson at 3:10 p.m., Saturday, February 26, at Milwaukee.

2. Roll Call

Councilors present were Doctors James, Lokvam, Dessloch, Heidner, McCarey, Bell, Garrison, Arveson, Ekblad, Galasinski, Bernhart, Casper, Wegmann, Zellmer, and Past-President Tenney.

Also present were Treasurer Weston; Vice-Speaker Fons; Drs. S. E. Gavin, D. H. Witte, and W. D. Stovall, Delegates to the American Medical Association; Drs. J. M. Sullivan and J. P. Conway, of the Committee on Public Policy (Saturday only); Dr. C. N. Neupert, state health officer; Dr. J. C. Griffith (Saturday evening only); and Mr. Lyle A. Limond, executive secretary of the North Dakota State Medical Association (Saturday only).

Special guests Saturday afternoon were Dr. F. S. Crockett, Indiana, chairman of the AMA's Council on Rural Health; Dr. L. W. Larson, North Dakota, member of the Board of Trustees of the AMA; and Dr. W. A. Wright, North Dakota, member of the AMA's Council on Rural Health.

Staff members and consultant present were C. H. Crownhart, secretary; Earl R. Thayer, assistant secretary; Robert B. Murphy, legal counsel; and Misses Joan Pyre and Jean McGruer of the Society's office.

3. Introduction of New Councilors

Chairman Arveson introduced Dr. W. D. James, Oconomowoc, and Dr. L. H. Lokvam, Kenosha, as the new councilors elected at the 1954 Annual Meeting.

4. Approval of Minutes

On motion of Doctors Bell–Dessloch, carried, approval was given to the minutes of the May 15–16, 1954, meeting, as published in the October 1954 issue of *The Wisconsin Medical Journal*, and the July 31–August 1, 1954, October 3, 1954, and October 6, 1954, meetings, as published in the December 1954 issue of *The Wisconsin Medical Journal*.

Minutes of the February 27–28, 1954, meeting, as published in the July 1954 issue of *The Wisconsin Medical Journal*, were approved at the October 3, 1954, meeting of the Council, on motion of Doctors Zellmer–Hemmingsen. That action was omitted in the minutes of that meeting and is recorded at this time.

At this point the secretary read the report of the Interim Committee, with its recommendation that the report be held over to Sunday for Council action.

5. Elections

President McCarey assumed the chair for this order of business.

a. *Chairman of the Council*—On motion of Doctors Zellmer–Galasinski, carried, Doctor Arveson was re-elected chairman of the Council for the ensuing year.

b. *Treasurer*—On motion of Doctors Dessloch–Garrison, carried, Doctor Weston was re-elected treasurer of the Society for the ensuing year.

c. *Secretary*—On motion of Doctors Ekblad–Zellmer, carried, Mr. Crownhart was re-elected secretary of the Society for the ensuing year.

d. *Editorial Director*—On motion of Doctors Galasinski–Casper, carried, Doctor Sullivan was re-elected editorial director of *The Wisconsin Medical Journal* for the one-year term.

6. Commission on Prepaid Plans

The secretary pointed out to the Council that the actual size of the Commission on Prepaid Plans had never been specifically stated. In order to clarify the records and to keep uniformity of action in the future, it was suggested that the Council amend its November 1951 statement as to the membership of the Commission as follows, with new material indicated in italics and material to be stricken in bold face type:

Membership

The membership of such Commission shall **be the present members of the several committees and** *consist of the president and president-elect and 20 physicians who* shall be participating physicians in the plans. **By lot, at the organizational meeting of the Commission, terms shall be selected so that** The terms of approximately one-third shall expire annually., **beginning February, 1953.** New appointments to the Commission shall be by the chairman of the Council.

On motion of Doctors Dessloch–Garrison, carried, the Council acted to amend the statement as recommended.

7. Interprofessional Institute

Dr. H. Kent Tenney, who was the chairman of the first Interprofessional Institute, held in January, was asked to report on this meeting. He said it appeared to be successful and a worth-while effort and that it was interesting to learn what other groups were doing in health matters. Doctor Ten-

ney said he felt progress had been made "toward understanding each other's problems and in knowing where we can unite in continued efforts for adequate health legislation in Wisconsin." He said further that he hoped the Institute would be continued in subsequent years.

8. Commission on State Departments

At the February 1954 meeting of the Council, the Commission on State Departments recommended that the terms of members of its divisions be for three years, with one-third expiring each year. Action of the Council at that time was to reconsider the matter in one year.

There was discussion on the subject, and the secretary pointed out that if the Council wished to approve the recommendation it should amend its original action creating the Commission on State Departments.

> It was moved by Doctors Galasinski–Garrison, carried, that the Commission on State Departments be granted authority to appoint the membership on its divisions for three-year terms, with approximately one-third of the terms expiring each year.

9. Charitable, Educational and Scientific Foundation, Incorporated, of State Medical Society of Wisconsin

In 1954 the Council recommended to the House of Delegates the establishment of a foundation to be used for scientific and research activities, and its report was printed in the *Handbook for Delegates* and in the transactions of the House in the December 1954 issue of *The Wisconsin Medical Journal*. At that time the House of Delegates adopted those recommendations, including that of organizing the details so that the House might take further action in 1955 to implement the program.

This history was reviewed with the Council; and the secretary asked that Mr. Murphy, legal counsel, be called on to go into further detail. Mr. Murphy then reviewed with the Council the proposed articles of incorporation and by-laws governing the organization of this corporation.

> After discussion, and on motion of Doctors Dessloch–Galasinski, carried, the proposed articles of incorporation and by-laws were approved for submission to the House of Delegates. (This material will be printed later in the transactions of the House of Delegates.)

The secretary pointed out that he should have authority to prepare administrative details in connection with solicitation of contributions to the foundation; and on motion of Doctors Casper–Bell, carried, the following resolution was adopted:

> *Resolved*, That following the incorporation of the Charitable, Educational and Scientific Foundation, Incorporated, of the State Medical Society of Wisconsin, the secretary be authorized to notify the membership of the Society that voluntary annual or other contributions to the Foundation are being strongly encouraged and will enable the Foundation to fulfill its purposes.
>
> *Be it further resolved*, That the secretary be authorized to prepare a form of notice for voluntary annual contributions, containing the figure to be established by the House of Delegates at its May 1955 meeting, which form will be sent to the entire active membership age 35 and over, such notification to cover the fiscal year ending June 30, the first of such notices to be mailed shortly after July 1, 1955.

10. Physician Licensure

In executive session the Council discussed the licensing of a physician in Wisconsin and authorized a communication to the State Board of Medical Examiners concerning it.

> *At this point Chairman Arveson introduced the honored guests, who were in Milwaukee participating in the program of the National Rural Health meeting. They were Dr. L. W. Larson, Bismarck, North Dakota, member of the AMA's Board of Trustees, who spoke briefly on the Commission on Medical Care Plans; Dr. F. S. Crockett, West Lafayette, Indiana, chairman of the AMA's Council on Rural Health; and Dr. W. A. Wright, Williston, North Dakota, member of the Council on Rural Health of the AMA.*
>
> *The meeting was recessed for dinner at 5:45 p.m., and reconvened for the evening session at 7:55 p.m.*

11. Section Delegates

It was recommended by the Interim Committee that Chapter XIII of the By-Laws relating to section organization for the purpose of delegate representation be repealed.

After considerable discussion of the subject, the Council, on motion of Doctors Bernhart–Ekblad, carried, recommended amendment of the Chapter to provide that section delegates be nonvoting members of the House.

It was further recommended, on motion of Doctors Ekblad–Bernhart, carried, that the section be amended to provide Council approval to the creation of new sections.

12. Recognition of W. S. Middleton, M. D.

In recognition of Dr. W. S. Middleton's many contributions to medicine generally and to the State Medical Society of Wisconsin, Chairman Arveson offered the following resolution, which was unanimously adopted on motion of Doctors McCarey and Tenney:

WILLIAM SHAINLINE MIDDLETON, M. D.

WHEREAS, Doctor William Shainline Middleton will on March 1, 1955, retire as Dean of the University of Wisconsin Medical School, to become

Chief Medical Director of the Veterans Administration, and

WHEREAS, Doctor Middleton, *the Physician*, is a distinguished clinician, one of the most popular and best loved doctors to serve the patients of the University Hospitals, a true servant of humanity, an advocate of the State Medical Society of Wisconsin, to which he contributed so generously through the creation of the Council on Scientific Work and leadership to the Student Loan Fund and Section on Medical History, and

WHEREAS, Doctor Middleton, *the Dean*, an able administrator and noted authority on blood and cardiovascular disease, has earned the everlasting gratitude of his students and the people of Wisconsin as the architect of a great medical school, welding the art and science of medicine to the minds of men so that they may be known as physicians, and,

WHEREAS, Doctor Middleton, *the Officer*, having already served his country above and beyond the call of duty in two world wars, and taking a leading roll in the establishment of an eminently successful program for the care of the disabled veterans, now takes up the reins of the world's largest medical administrative position,

Now, therefore be it resolved, That Doctor Middleton, *the Man*, beloved by his patients and students, honored by educators and praised by Governments, receive the heartfelt thanks and appreciation of the Council of the State Medical Society of Wisconsin for his outstanding contributions to medicine and public health in Wisconsin, and its sincerest best wishes for a most successful future.

13. Wisconsin Pharmaceutical Association

Confirmation was requested of the Council of the mail ballot dated January 10, 1955, in connection with the recommendation of the Committee on Public Policy as to the policy of the State Medical Society with reference to letters written on January 3, 1955, by the Wisconsin Pharmaceutical Association to the presidents of 11 county medical societies in complaint of specifically named physicians asserted to be engaged either in "commercial dispensing" or in the establishment of "a clinic pharmacy."

The policy statements, which follow, were approved by the Council, on motion of Doctors Zellmer–Ekblad, carried:

(1) The profession of medicine is and must remain the sole judge of the application of its Principles of Medical Ethics.

(2) Each county medical society be apprised of the current project of the Wisconsin Pharmaceutical Association.

(3) All county medical societies be asked to examine the adequacy of pharmaceutical services in their respective areas whether or not the areas are involved in the current controversy.

(4) Each county medical society be asked to consider this matter as of local and not statewide nature.

(5) Efforts be made to secure clarification of the Principles of Medical Ethics as now phrased.

14. Legislative Report

Recommendations as to current legislative proposals were reviewed by Drs. Sullivan and Conway, on behalf of the Committee on Public Policy.

The recommendations included approval of proposals offered by the State Board of Medical Examiners regarding reconstitution of the Statutory Medical Grievance Committee, provisions for a temporary license in cases of emergency when the applicant meets all other requirements but cannot be examined for more than 30 days because of the Board schedule, and provision for an increase in license fees.

The committee recommended approval of a measure providing that school boards in Milwaukee County may require periodic health examination of school employees (now provided in all other counties), and a measure establishing a medical examiner system throughout the state.

It was recommended by the committee that Bill 139, S., by the Wisconsin Optometric Association, requiring 16 hours annual postgraduate education, including ocular pathology, as a condition for registration of license be opposed . . . also Bills 262, A. and 266, A., of the Wisconsin Pharmaceutical Association, changing the definition of, and giving the State Board of Pharmacy the authority to define, dangerous drugs, and making certain changes in the narcotic law and regarding the sale of exempt preparations at retail . . . and Bill 88, A., requiring employers to list specialists on the Workmen's Compensation panel, as impractical.

It was recommended that Bill 224, A., requiring applicants for chiropractic license to "present sufficient and satisfactory evidence of education equivalent to the first two years of study in a regularly prescribed course for a bachelor of arts or science degree in an accredited college granting such a degree," be opposed unless amended to provide that such institution be accredited to the University of Wisconsin and provide courses whose credits are fully transferable to the university for undergraduate or graduate work; that Bill 245, A., increasing annual registration fees for chiropractors and empowering the chiropractic board to employ an investigator to investigate violations of those sections of the Medical Practice Act "which affect chiropractors or the practice of chiropractic," be opposed on the grounds that enforcement of the Medical Practice Act is the responsibility of the State Board of Medical Examiners.

Other miscellaneous matters reported included recommendations as to safety belts for automobiles, civil defense, unemployment compensation, health plans for state employees, and chiropody, all of which were approved generally by the Council.

15. AMA Delegates

On advice of the American Medical Association that with an active membership of 3,006, the State Medical Society of Wisconsin is entitled to an additional delegate, the Interim Committee reported the following recommendations:

a. The appointment of Dr. J. C. Griffith, Milwaukee, as a delegate to the AMA.

On motion of Doctors Heidner-Wegmann, carried, Doctor Griffith was appointed the new delegate to the American Medical Association.

b. The appointment of Dr. R. E. Galasinski, Milwaukee, as alternate delegate for Doctor Griffith.

On motion of Doctors Ekblad–Bell, carried, the appointment of Doctor Galasinski as alternate delegate for Doctor Griffith was approved.

c. That the president-elect, by tradition, be appointed as an alternate delegate—in this case, that Dr. E. L. Bernhart, Milwaukee, be appointed to serve in place of Doctor Griffith, as alternate to Doctor Witte.

On motion of Doctors Bell–Dessloch, carried, Doctor Bernhart was appointed alternate delegate for Doctor Witte.

The Council adjourned at 10:00 p.m., Saturday and reconvened at 10:00 a.m., Sunday, February 27, 1955.

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16. American Medical Education Foundation

Doctor Heidner expressed his concern over the relatively small amount of contributions made to the AMEF and said he felt Wisconsin was not meeting its obligations in this project. He recommended that some concerted effort be made through county societies to encourage members to contribute to the Foundation.

It was pointed out by the secretary that this could be done through the mechanisms of the Charitable Foundation of the State Medical Society after July 1, if the House of Delegates approved its organization.

17. School Vision Screening Program

Through the Division on Visual and Hearing Defects, the Section on Ophthalmology and Otolaryngology, and the Wisconsin Optometric Society, a school vision screening program was worked out and presented to the Commission on State Departments, which approved it and recommended it to the Council for final action.

Dr. John Hitz, Milwaukee, representing the Section on Ophthalmology and Otolaryngology, reviewed the following outline with the Council:

An Outline to Facilitate the Development of a School Vision Screening Program

(Approved by the Commission on State Departments, December 16, 1954.)

I. PURPOSE:

To detect significant visual defects among school children.

II. ORGANIZATION AND DEVELOPMENT:

A. Planning Committee:
1. Public Health Nurse: County, City or School Nurse.
2. Health Officer: District, County or City Health Officer.
3. County Medical Society:
   a. One member of The Executive Committee.
   b. Ophthalmologists.
   (If no ophthalmologist is available locally, one from another county or city could serve.)
4. Area Optometric Society:
   a. Optometrists.
5. School Representatives:
   a. Superintendent or Principal.
   b. Teachers.
6. Parent Representatives:
   a. Parent Teacher Association.
   b. Health Council.
7. Other interested persons.

B. **Continuing Professional Advisory Committee: To select tests, to establish standards, and to evaluate the program as it continues.**
1. Public Health Nurse.
2. Ophthalmologists.
3. Optometrists.

C. Screening Methods:
1. Selection of the vision test or tests to be used: (It is emphasized that no specific test is foolproof. Good results depend upon intelligent administration of the tests and careful interpretation of the findings.)
   a. Snellen test charts—equipped with a source of standard illumination. (Time-tried and satisfactory means of testing visual acuity for distance.)
   b. Acceptable mechanical devices for screening purposes may be used by adequately trained personnel. The results of these tests should be realistically evaluated to avoid over-referral:
      (1) Massachusetts Vision Test.
      (2) American Optical Company Sight-screener.
      (3) Keystone Telebinocular.
      (4) Bausch and Lomb Orthorater.
2. It is suggested that, as an additional part of the screening procedure in testing distance visual acuity, a pair of plus 2.00 D. Spheres be placed before the eyes to reveal high degrees of hyperopia. How-

ever, referral on this basis alone must be carefully evaluated to avoid over-referral.

3. The value of tests for color vision, heterophoria, and stereopsis, as applied to school vision screening programs, is doubtful.
4. Grades to be screened:
   a. Annual vision screening of school children is recommended. It is suggested that, as a minimum program, grades one, four, and seven, as well as all new pupils in the school and those observed by the teachers as possibly having visual defects, be screened annually. The vision testing program can conveniently be synchronized with the hearing screening program.

III. ADMINISTRATION:

A. **A Director of the program should be named by The Planning Committee. It is recommended that the Director not be an optometrist or a physician.**

B. **The teacher or volunteer lay women, trained by the Continuing Professional Advisory Committee and/or the Public Health Nurse under the direction of the Committee, to administer the initial vision screening tests.**

C. **Public Health Nurses, or especially trained and proficient lay persons to recheck children who fail initial tests.**

D. **All children having unsatisfactory vision tests, as well as those having significant visible eyelid or ocular defects, to be referred for further eye examination and refraction.**
   1. Form letter to parents of the child with a visual defect advising further examination by an eye doctor. This letter should include space for the recording, by the examining doctor, of his recommendations. This letter, with the recommendations of the eye doctor added thereto, is to be returned to the Director of the program.

E. **Follow-up letters and visits by the Public Health Nurse if the referral recommendation is ignored.**

F. **Liaison between Public Health Nurse and classroom teachers.**

IV. EMPLOYMENT OF SPECIAL FUNDS TO FACILITATE THE PROGRAM:

A. **The interest of service clubs and of other private organizations may be sought.**

B. **Uses of such funds:**
   1. Purchase of screening test equipment.
   2. Clerical, stationery, and mailing costs.
   3. Financial aid for professional fees and glasses in needy cases.

After a long discussion, the school vision screening program, as outlined, was approved on motion of Doctors Tenney–Bernhart, carried, although Doctor Galasinski asked to be recorded as voting "no."

18. 1955 Budget

In addition to the budget itself, the Audit and Budget Committee had the two following recommendations for Council approval:

(a) $7,000 be transferred from the general funds of the State Medical Society to the SMS Realty Corporation for the specific purpose of furnishings for the new building.

(b) Earl R. Thayer, assistant secretary, be authorized, in addition to C. H. Crownhart and Roy T. Ragatz, to sign checks of the State Medical Society.

The 1955 budget was reviewed item by item, and approved with the above recommendations, on motion of Doctors Bernhart-Zellmer, carried. The budget follows:

Account	*Budget Item*	*Appropriation*
53	CENTRAL OFFICE NORMAL OPERATING EXPENSE	
531	*President's Travel.* This standing appropriation to the president avoids the necessity of his vouchering the costs of his attendance at meetings in behalf of the Society. The president, as well as the president-elect, is notified of all committee meetings and is expected to attend many of them. The president is chairman of the Council's Interim Committee, which meets monthly; and he attends many county society, state, and other meetings.	$750
532	*Council, Officers, Delegates, and Committee Meeting Expense.* This appropriation covers the cost of meetings of the Council, monthly meetings of the Interim Committee, meetings of the Society's numerous committees, and travel expenses of three delegates to the 1955 A.M.A. meetings to be held in Atlantic City and Boston. This account also provides for reimbursement of meeting expenses to councilors and committee members, who are entitled to bill for travel expenses. If all such costs were billed, a much larger appropriation would be required.	11,500
533	*Association and Dues Expense, State and National Organizations.* The Society holds memberships in, or supports, the following organizations, including membership for the secretary in clubs in Madison and Milwaukee, their facilities being used frequently for meetings and overnight accommodations:	
	North Central Conference (State Medical Association of Wisconsin, Minnesota, the two Dakotas, Nebraska, Iowa)	$100
	Conference of Presidents	75
	National Society of Medical Research	50
	Wisconsin State Chamber of Commerce	50
	Better Business Bureau of Milwaukee	50
	World Medical Association	10
	Club Memberships	250

Account	Budget Item	Appropriation
	Wisconsin Public Health Council, charter membership 100 American and State Hospital Associations, Medical Society Executives Conference, etc., approximately 165	$850
534	*Resource and Informational Material.* Various pamphlets and other publications are purchased and supplied to officers, councilors, and various members of committees, relating to specific activities or responsibilities. New materials are necessary to effectively discharge official duties of the Society.	500
535	*Woman's Auxiliary to the State Medical Society.* In addition to assisting the Auxiliary in the program of the Annual Meeting ($500 annually), an appropriation has been provided to reimburse for stenographic work, mailing, and other expenses. Intensified efforts involved in the fields of health education and nurse recruitment have required an increased activity by the Auxiliary membership and other women's organizations. This appropriation also covers the expense of printing and mailing the quarterly bulletin of the Auxiliary.	1,000
536	*Accounting and Insurance.* Covers the cost of the annual audit required by the State Medical Society and provides for services in connection with administrative procedures and income control. This appropriation also provides for Workmen's Compensation insurance and the comprehensive bond insurance expense for employees	2,000
537	*Rent.* Exact rental for the new building cannot be determined at this time, although the secretary estimates that it will approximate $40,000. Assuming that the Society is able to enter the building in the month of June, it is estimated that the total 1955 rental will be distributed as follows:	

	Present Location	New Building	Total
State Medical Society	$3,200	$ 8,800	$12,000
Wisconsin Physicians Service	4,550	15,450	20,000
Wisconsin Medical Journal	250	250	500
	$8,000	$24,500	$32,500

Account	Budget Item	Appropriation
538	*Telephone and Telegraph.* Line charges are paid from building funds so that each agency shares the cost of lines and the switchboard according to the number of extensions used by those departments. This appropriation carries the cost of long distance calls and telegrams.	12,000
539	*Printing and Office Supplies.* This account carries the cost of printed envelopes and stationery, membership supplies, mineograph paper, reprints, and other printed materials. It also provides for the cost of folders, photostat materials, stencils, carbon paper, and other miscellaneous office supplies.	1,800
5310	*Postage and Express.* Covers the cost of mailing membership certificates, general correspondence, and other normal requirements. It does not include the cost of mailing *The Wisconsin Medical Journal* which is paid through the Journal account.	$4,500
5311	*Upkeep and Fixtures.* This account is chiefly one of maintenance. It provides for service agreements for the robotyper, the mimeograph machine, and electric typewriters, and repairs for adding machines and standard typewriters. The cost of maintaining addressograph plates, of which there are approximately 5,000 in current use, is also reflected in this appropriation.	3,500
5312	*New Equipment.*	500
5316	*Depreciation.* It is recommended that depreciation replace the classification of New Equipment in the operating budget, and that the request for approval of capital expenditures be submitted separately. The amount of $2,100 represents the estimated depreciation for 1955, based on an average rate of 10 per cent of fixed assets.	2,100
5318	*Legal.* Our attorneys are frequently contacted directly by doctors and others for advice, and these requests are always cleared with the office before being fulfilled. However, when such requests are made by various state groups, they cannot be ignored. In addition, the attorneys advise the individual officers relative to their activities in behalf of the Society, attend all meetings of the Council and certain of the major committee meetings. Many of these are treated without billing inasmuch as the appropriation amounts in part to a type of retainer.	3,600
5319	*Bulletin on A. M. A. Meetings.* This account carries the biannual reports of the delegates to A. M. A. meetings. It is for printing only and does not include postage.	600
5320	*Blue Book Issue, Special Appropriation.* This is an annual appropriation to *The Wisconsin Medical Journal* to assist in carrying the increased cost of issuing the Blue Book edition of the Journal, which is furnished to the junior and senior classes of the medical schools and to new members.	2,000
5325	*Miscellaneous.* This is an overflow account for items which the staff does not anticipate or the assignment of which to any of the preceding accounts is not logical.	1,000
54	PUBLIC HEALTH INFORMATION, SPECIAL ACTIVITY	
541	*Today's Health.* This publication is sent by the Society to elected public officials and others who have	

Account	Budget Item	Appropriation
	special interest in public health matters. The circulation amounts to approximately 310, and the expressions of appreciation are obviously sincere.	$500
542	*Lay Publications.* This appropriation is provided to cover the cost of furnishing health studies; various health reports, including surveys of physician distribution; and public health procedures to those passing on various public health proposals. This account is used biennially but budgeted annually. The total proposed budget for 1955 represents an appropriation of $200 from 1955 membership dues, and a recommended carry-over of the 1954 unexpended balance in the amount of $300.	500
543	*Special Bulletins.* This account is budgeted on an annual basis but used biennially. It covers the cost of special bulletins dealing with proposed changes in laws affecting various public health problems. It is recommended that $300 of the 1954 unexpended balance in this account be used as a carry-over and that an additional amount of $500 be appropriated from dues.	800
544	*Wisconsin Medical Journal Special Inserts.* During many legislative years, special inserts are printed in *The Wisconsin Medical Journal.* This appropriation is budgeted annually and paid in a lump sum to *The Wisconsin Medical Journal* account, where it has been fully utilized, inasmuch as the Journal also carries a considerable amount of information relative to activities in other states and nationally. A carry-over of the unexpended 1954 balance of $500 is recommended, and an additional appropriation of $300 is provided from current dues to insure a total available budget of $800.	800
545	*Special Telephone and Telegraph.* This is also an account used only biennially but budgeted annually. A carry-over of $300 of the 1954 unexpended balance is requested, in addition to the current appropriation of $350.	650
546	*Legislative Counsel.* This is a retainer appropriation paid annually for services rendered chiefly during the legislative session, although interim studies of the legislature, as well as of the State Medical Society, also command a considerable amount of time of the legislative counsel. It is important to note that the position of the Society is such that its advice on public health legislation is sought on many occasions. The amount of time required of legislative counsel during the actual session amounts to more than full-time service of one man for a six months' period.	4,200
547	*Miscellaneous.*	——
55	PUBLIC HEALTH INFORMATION, PRESS AND RADIO	
551	*Press Releases.* Each year requires the preparation of special releases relating to various positions taken by the medical profession; special activities of the Medical Society such as the Annual Meeting; information to the press relative to content of *The Wisconsin Medical Journal,* particularly that dealing with medical-economic matters. The Wisconsin Press Association handles the distribution of such releases through a special arrangement.	$300
552	*Health Conferences, Exhibits, and Publications.* This account will carry the expenses incurred in connection with the National Rural Health Conference to be held in Milwaukee on February 24–26, 1955. The Society also meets requests for exhibits such as those provided for the Wisconsin Farm and Home Week, the annual meeting of the Farm Bureau, and conventions of similar organizations. A special allotment of $200 from this account supports the health activities among the local 4–H Clubs through the state 4–H office.	1,000
5530	*March of Medicine, Recording.* The March of Medicine is carried on 42 stations, including nine on WHA (the state station in Madison) FM network. This account carries the cost of interviews and recording of tapes.	800
5531	*March of Medicine, Supplies.* This account provides a moderate appropriation for replacing tapes, providing mailing cases, and other miscellaneous items. Also included is a sum sufficient for dictating and mimeograph supplies. The program produces "fan mail" varying from 200 to 400 letters a month. Inquiries are personally answered by Doctor Parkin and transcribed in the office.	250
5532	*March of Medicine, Printing and Postage.* Health spot announcements are available to 69 Wisconsin stations, together with seven radio stations in areas bordering on Wisconsin. These are circulated monthly, and the response from the radio stations is excellent. This account also carries the postage expense in connection with mailing tapes for the March of Medicine.	350
5533	*March of Medicine, Television.* The current series of television programs sponsored by the State Medical Society, in cooperation with Station WHA–TV, will be concluded on April 22. Another 13-week series is scheduled for presentation during the last half of 1955. Starting at mid-year, the Society will make available to county societies and their local TV stations all kinescopes produced during the first series. It is recommended that $300	

Account	Budget Item	Appropriation
	of the 1954 unexpended balance be used as a carry-over, and that an additional amount of $1,200 be appropriated from current dues, providing a total 1955 budget of $1,500.	$1,500
554	*Miscellaneous.* This account is for the miscellaneous items in the six preceding accounts.	300
56	MEDICAL SERVICE, OPEN PANELS This classification relates to the preparation and distribution of approximately 80,000 panels provided for posting in plants and other establishments subject to the Workmen's Compensation Act. The project, which will be carried out on a three-year basis, requires continuing activity. The amounts recommended are treated as a revolving appropriation. Panels are prepared on a county basis, and reprints are available in bound volumes to various insurance companies and other organizations desiring them. The income from reprints recovers about $500 of the total expense incurred by the Society.	
561	*Applications and Correspondence.* Members newly enrolled in the Society are circulated as to their desire to be placed on the panel; and in the preparation of the panel itself, all physicians must be contacted for verification of address, telephone numbers, listing under the two specialties available (eye, ear, nose and throat; or eye only). New members sometimes request communications to plants within their areas, advising that their names have been approved for panel listing and will be included on the new panel.	200
562	*Panel Printing.* This account carries the cost of printing approximately 80,000 panels county by county, and 150 bound volumes. 120,000 form letters are circulated, one series signed by the Industrial Commission and the other by the State Medical Society.	1,000
563	*Envelopes.* This covers the purchase of envelopes for panel distribution. No appropriation is included for 1955.	——
564	*Postage and Addressing Costs.* Panel addressing is done manually and requires the checking of individual records by a part-time employee. The cost of part-time assistance will be in the neighborhood of $900, with postage amounting to approximately $1,000.	500
565	*Miscellaneous Expense.* This account is for miscellaneous items not anticipated in the four preceding accounts.	150
57	ANNUAL MEETING The Annual Meeting involves 20 separate accounts, and a separate financial report relative to it is distributed to councilors and officers. The Annual Meeting expenses are handled as a revolving account with income from exhibits, the Annual Dinner, and miscellaneous items turned back to the cost of the meeting. In addition, budgetary allotment is provided. Although 1954 Annual Meeting income exceeded expenditures by $1,500, an appropriation of $1,000 is requested for 1955. Exhibit space rental for 1955 is estimated at $15,600, as compared with the sale of 1954 exhibit space amounting to $16,400. In addition it is anticipated that expenses of the 1955 Annual Meeting will be slightly higher than those incurred in 1954.	$1,000
58	TEACHING CLINICS, INDUSTRIAL HEALTH CLINICS AND COUNCILOR DISTRICT MEETINGS	
581	*Teaching Clinics, General.* This includes the circuit teaching programs and any special meetings. While registration fees are charged, these do not recover the expense of the clinics, which involve speaker honoraria, printing and postage, speaker meals, and hotel. Salary and staff travel are not allocated. The State Board of Health, the American Cancer Society, the Wisconsin Heart Association, and the Wisconsin Anti-Tuberculosis Association each participate financially to support certain phases of the clinics.	1,000
582	*Industrial Health Clinics.* The Industrial Hygiene Unit of the State Board of Health gives financial assistance by way of partially underwriting the printing and postage expenditures and contributing the major support for the reimbursement of speakers. The Society, other than staff assignment, pays for promotional expenses and speaker travel.	600
583	*Councilor District Meetings.* Five councilor district meetings were held during 1954; namely, Fifth, Sixth, Seventh, Tenth, and Eleventh districts. Speakers were secured and traveling expenses paid. No appropriation is included for 1955.	——
584	*Special Scientific Teaching Programs.* One medical clinic on mental deficiency, such as was held at Northern Colony last year, is likely to be arranged at Southern Colony; and the Society is expected to incur some costs in support of several M.D.—dentist clinics on oral cancer. The guide for nurses in industrial health must be revised this year, and the Society may be required to share in the cost of its production and distribution. Appropriations for these activities are recommended as follows:	
5841	Medical Clinics on Mental Deficiency	200
5842	M.D. — Dentist Clinics on Oral Cancer	100

Account	Budget Item	Appropriation
5843	Industrial Health	$200
585	*Special Conferences.* Three additional school health conferences should be held in 1955 in order to complete the state circuit. They would be held at Superior, La Crosse, and Whitewater or Platteville. The following appropriation is recommended:	
5851	Conferences on School Health	900
59	WISCONSIN MEDICAL JOURNAL	
	The Wisconsin Medical Journal is provided for each member of the Society and to subscribers, advertisers, medical societies, senior medical students of the two medical schools in Wisconsin, and others to a total of approximately 3,900. The Journal is the official publication of the Society and under the Constitution and By-Laws is required to carry certain official reports and notices such as minutes of the House of Delegates.	
	Advertising rates for the Journal are studied annually and are in line with other state medical journals of comparable size and circulation. Practically all advertising is obtained through the State Journal Advertising Bureau maintained in A.M.A. headquarters by participating journals of most state medical organizations. Advertising policies of the Journal are in conformity with advertising policies of the American Medical Association, although some further restrictions have been imposed.	
	This is a revolving account, and none of the salary of the secretary or assistant secretaries is assigned to the Journal. One full-time employee acts as assistant editor, and the salary of that employee is carried from the Journal account. Printing costs have advanced substantially during the past several years; and because advertising contracts and rates must be established as much as 18 months in advance, the business management of the Journal is difficult with so limited a circulation in advertising appeal. The suggested appropriation represents estimated Journal costs in excess of advertising revenue.	3,600
5901	VETERANS AGENCY AND PREPAID PLANS	
59014	*Veterans Medical Service Agency.* Under the contract with the Veterans Administration and the policy of the general accounting office, committee, travel, and meeting expenses are non-recoverable, as are a few other items. This appropriation is included to cover expenses which require underwriting by the Society.	200
	TRAVEL BUDGET	
59031	*Secretary's Travel*—C. H. Crownhart	1,800
59032	*Assistant Secretary's Travel*—R. T. Ragatz	$1,000
59033	*Assistant Secretary's Travel*—E. R. Thayer	1,800
59034	*Field Secretary's Travel*	1,500
59035	*Claims Manager and SMS Consultant's Travel*—T. J. Doran	200
59036	*Medical Advisor's Travel* (For radio activity) — R. C. Parkin, M. D.	250
59037	*Miscellaneous Travel.* This appropriation covers the expenses of various individual staff members who are directed to attend some particular meeting at which it is more logical that they be present than others outlined in the budget.	300
5904	*Group Insurance.* This appropriation covers the contribution by the State Medical Society for employees eligible for Blue Shield and Blue Cross coverage based on contracts in effect January 1, 1955.	900
5905	*Employment Taxes.* Social Security taxes are computed at 2 per cent of total payroll up to $4,200 on each individual. Wisconsin Unemployment Compensation tax is computed at 1½ per cent of total payroll up to $3,000 on each individual. Federal Unemployment Compensation tax is computed at 3/10 per cent of total payroll up to $3,000 on each individual.	1,800
	Payroll as Reported in Payroll Budget	86,370
	Retirement Program	3,900
	Grand Total	$169,620

PAYROLL BUDGET 1955*

1. Secretary	$ 20,000
2. Assistant Secretary, Scientific, one-third time, Roy T. Ragatz	5,000
3. Assistant Secretary, Economic, Earl R. Thayer, allocation from budget (total annual salary $11,000)	4,250
4. Claims Director of Prepaid Plans and Veterans Agency Director, T. J. Doran, allocation from budget (total annual salary $11,250)	1,200
5. Field Secretary, vacant, allocation from budget (total annual salary budgeted $6,600)	3,000
6. Comptroller, R. J. Hoops, allocation from budget (total annual salary $9,000)	4,500
7. Three positions of executive assistant	11,100
8. Two positions of supervisor	5,715
9. Five positions of administrative assistant	16,095
10. Five secretaries	11,925
11. One stenographer	2,340
12. One clerk, allocated	1,245
Total	$ 86,370

*The Society had a total of 56 employees as of February 1955. Other employees are carried on the budgets of either Blue Shield or the Veterans Agency; and in any event, salaries are reviewed by the Audit and Budget Committee for consistency.

19. Student AMA at House of Delegates

After consultation with the official representatives of the State Medical Society to each of the two Wisconsin chapters of the Student American Medical Association, it was recommended by the staff that the Council authorize these observers to be seated with the delegates from Madison and Milwaukee in an effort to bring them more closely into acquaintance with proceedings of the House.

The Council approved this recommendation on motion of Doctors Dessloch–Ekblad, carried.

20. Physician Members of the Blue Cross Corporation

The Council confirmed, on motion of Doctors Heidner–Casper, carried, its mail ballot of October 19, 1954, regarding approval of three 1954 appointees to corporate membership in the Blue Cross Corporation.

21. Council Committee Terms

It was moved by Doctors Galasinski–Bernhart to extend the terms of Council committee members to May to bring them into uniformity with terms of standing committee members who are appointed by the president at the time of the Annual Meeting. The motion carried.

22. Resolution on Advertising of Alcoholic Beverages

A resolution to prohibit the advertising of alcoholic beverages in *The Wisconsin Medical Journal* was presented to the Council for consideration. After some discussion, and on motion of Doctors Ekblad–Zellmer, carried, the resolution was tabled.

23. Report to the House of Delegates by Secretary of State Board of Medical Examiners

A staff recommendation to establish a tradition of having the secretary of the State Board of Medical Examiners present a brief oral report to the House of Delegates was approved, on motion of Doctors Zellmer–Galasinski, carried.

24. Special Report to the Interim Committee

In executive session the Council reviewed a special report recommended by the Interim Committee regarding scientific studies and investigations. The report was adopted on motion of Doctors Dessloch–Zellmer, carried.

25. Appointments to State Boards

The Council was reminded that under statutory authority the State Medical Society may submit to the Governor nominations for appointments to certain state boards from which he may, but need not, select.

Nominations for two appointments to the State Board of Medical Examiners were presented by the Interim Committee, and approved by the Council on motion of Doctors Garrison–Casper, carried.

26. Advertising, Wisconsin Medical Journal

Advertising of a product in *The Wisconsin Medical Journal* has been predicated on the basis that it be a product accepted by the American Medical Association for advertising, and consequently given the "seal of acceptance." The AMA advises that, as of February 19, it is withdrawing the seal of acceptance in the pharmaceutical and other fields.

Therefore, the Interim Committee recommended as a temporary policy, pending a final report from the AMA, that advertising in *The Wisconsin Medical Journal* be accepted from those companies that have previously had accepted products.

On motion of Doctors Bell–Dessloch, carried, the Council approved this recommendation.

27. Adjournment

There being no further business, the annual meeting of the Council was adjourned at 12:30 p.m., Sunday, February 27, 1955.

C. H. Crownhart,
Secretary

Approved:
R. G. Arveson, M. D.,
Chairman

FILM ON CLEFT PALATE CHILD AVAILABLE

A new movie, "The Wisconsin Cleft Palate Story," in sound and color, has been produced by the Bureau for Handicapped Children, Department of Public Instruction, in cooperation with the University of Wisconsin Medical School, Department of Speech, and University Hospitals. It shows the integration of services necessary in the habilitation of a cleft palate child. This 36-minute film tells the story effectively and honestly.

The film can be rented from the Bureau of Visual Instruction, University of Wisconsin, 1323 West Johnson Street, Madison, Wisconsin, for a nominal fee. It is available for purchase through the Photographic Laboratory, 1204 West Johnson Street, University of Wisconsin Extension Division, Madison, Wisconsin.

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WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON PREPAID PLANS

April 19, 1955

To: Blue Shield Plan Directors

From: James F. Coleman

Re: Contributory Health Insurance for Federal Employees

In the evolution of the above-proposed bill, we have reached the point where the protracted discussions among Blue Shield, Blue Cross, the insurance industry, and the U. S. Civil Service Commission representatives have been completed. It is believed that the bill in its final draft stage provides both Blue Shield and Blue Cross with an excellent opportunity to obtain their proper share of the business, should the bill be enacted in that form.

Latest developments, however, make it appear problematical whether the Administration will actually send the bill to Congress for consideration. Such a decision by the Administration would appear to evolve upon the actual solution to the vexing problem of a pay raise for Federal employees now confronting both Administration and Congress. Many feel that the Congress will not wish to enact anything less than an 8% pay raise for Federal employees. If such should prove to be the case, it may be that the Administration will not submit the Health Insurance bill at this session of Congress and even if it should, Congress may not give it consideration.

To those of us who have been in on these discussions from the beginning, it becomes increasingly apparent that the important thing to be done right now, whether or not a bill is enacted at this session, is to enroll just as many Federal employees in Blue Cross and Blue Shield as we possibly can.

Although having an Enrollment Committee is important in itself, it is ever so much more important that each Blue Shield Plan from day to day be enrolling Federal employees.

James F. Coleman, *Chairman*
Special Blue Shield Committee
on Federal Employees Coverage

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3. The Rotation (swivel chair) Test. *The patient sits in a swivel chair with his eyes closed and his head on a level plane. The chair is turned through ten complete revolutions in twenty seconds. Stimulation of a normal labyrinth will cause nystagmus, past pointing of the arms and subjective vertigo.*

Notes on the Diagnosis and Management of "Dizziness"

I. Vertigo

The term "dizziness" (vertigo) should be restricted to the sensation of whirling or a sense of motion.[1] This sensation is usually of organic origin and is the tangible symptom of a specific pathology.

Moderate vertigo, with a sense of motion and a whirling sensation, may be produced by infection, trauma or allergy of the external or middle ear. Examination of the ear will usually disclose the abnormality.

Severe vertigo, which will not permit the patient to stand and causes nausea and vomiting, indicates an irritation or destruction of the labyrinth. The specific condition may be labyrinthine hydrops, an acute toxic infection, hemorrhage or venospasm of the labyrinth or a fracture of the labyrinth. Multiple sclerosis and pathology of the brain stem should be considered also.

It is important to learn if the patient's sensation is continuous or paroxysmal.[2] Paroxysmal vertigo suggests specific conditions: Ménière's syndrome, cardiac disease and epilepsy. Continuous vertigo without a pattern may be due to severe anemia, posterior fossa tumor or eye muscle imbalance.

Dramamine® has been found invaluable in many of these conditions. In mild or moderate vertigo it often allows the patient to remain ambulatory. A most satisfactory treatment regimen for severe "dizziness" is bedrest, mild sedation and the regular administration of Dramamine.

Dramamine is also a standard for the management of motion sickness, is useful for relief of nausea and vomiting of radiation sickness, eye surgery and fenestration procedures.

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1. Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.

2. DeWeese, D. D.: Symposium: Medical Management of Dizziness: The Importance of Accurate Diagnosis, Tr. Am. Acad. Ophth. *58*:694 (Sept.-Oct.) 1954.

SEARLE

Society Proceedings

Ashland–Bayfield–Iron

On March 30 the Ashland–Bayfield–Iron County Medical Society met at the Menard Hotel in Ashland to hear an address by Dr. Samuel H. Boyer, internist of Duluth, Minnesota. Eleven members of the society attended.

Barron–Washburn–Sawyer–Burnett

The Barron–Washburn–Sawyer–Burnett County Medical Society met on March 8 at the Elks Club, Rice Lake. Fifteen members were present at the meeting.

A report on the Rural Health Conference, held recently in Milwaukee, was presented by *Dr. J. F. Maser* of Rice Lake. Other business included a vote of approval to support the polio vaccination program, if last year's trials produced favorable results. A doctor was appointed to help public health personnel set up the program in each county.

The society also approved a plan to examine Boy Scouts who plan to enter Camp Phillips and a St. Paul area camp on Long Lake. A list of names of doctors who would examine the scouts on Sundays was to be compiled.

A motion picture of Mexico was also shown.

At the April 12 meeting of the society, held at the Elks Club, Rice Lake, 19 members heard a presentation of three cases of lung and heart disease, two of bronchogenic carcinoma, and one of pulmonary infarction with arteriosclerotic heart disease. These cases were presented by Dr. S. H. Boyer of Duluth. A discussion period followed the case presentations.

Brown–Kewaunee–Door

The Brown–Kewaunee–Door County Medical Society met on April 14 at the Elks Club, Green Bay, to hear a talk on "Health Insurance" presented by Mr. John LaBissoniere of the staff of Wisconsin Physicians Service, and Mr. Robert Froehlke, assistant secretary of Hardware Mutuals Insurance Company.

The speakers were introduced by *Dr. Guy Carlson* of Appleton, chairman of the Committee on Physicians and Public Relations of WPS. A question-and-answer period followed the discussion.

Dane

The April meeting of the Dane County Medical Society, held on April 12 at the Madison Club, Madison, was devoted to a discussion of the Blue Shield program.

Madison physicians who participated in a panel discussion of the program were *Dr. Russell Sinaiko, Dr. N. A. Hill, Dr. J. S. Supernaw, Dr. Peter Golden, Dr. W. V. Luetke, and Dr. T. J. Nereim.* A general discussion by the members at large followed.

Fond du Lac

Dr. Francis Rosenbaum, professor of internal medicine at Marquette University School of Medicine, Milwaukee, was the guest speaker at the March 24 meeting of the Fond du Lac County Medical Society held at the Elks Club, Fond du Lac. His subject was "The Physiology and Management of Auricular Fibrillation and Auricular Flutter." Discussants were *Drs. A. M. Hutter* and *H. J. McLane* of Fond du Lac. Forty-two members of the society were present at the meeting.

Kenosha

On March 16, members of the Kenosha County Medical Society participated in a luncheon and plant tour of American Motors Corporation at Kenosha.

The visit was arranged through the Kenosha Manufacturers Association, Industrial Safety Council, as part of its program for maintaining safe and healthful working conditions in Kenosha's manufacturing plants.

Manitowoc

At the April 21 dinner meeting of the Manitowoc County Medical Society, Dr. Samuel M. Feinberg, professor of medicine and chief of the Allergy Clinic at Northwestern University Medical School, Chicago, was the guest speaker. His talk was entitled "Allergy Induced by the Doctor; Recognition, Prevention, and Treatment."

The meeting was held at 6:00 p.m. at the Hotel Manitowoc, Manitowoc.

Oconto

Members of the Oconto County Medical Society met on March 15 at the Lilac Club, Gillett, to hear a discussion of "The Use of the Cytology Laboratory" by *Dr. R. J. Rogers* of Oconto. Five members attended.

Dr. H. A. Aageson and *Dr. F. E. Zantow,* both of Oconto, were appointed delegate and alternate delegate, respectively, to the House of Delegates of the State Medical Society.

Outagamie

"The Early Diagnosis of Psychosomatic Disease" was the subject of *Dr. Marc J. Musser* when he addressed 48 members of the Outagamie County Medical Society on March 17 at the Kaukauna Community Hospital. Doctor Musser is professor of medicine at the University of Wisconsin Medical School, Madison.

This meeting was held at the new hospital prior to its official opening the following week. Members of the Woman's Auxiliary met with the physicians. Mrs. Robert T. Schmidt of Green Bay, state subscription chairman of *Today's Health* magazine, gave a short talk concerning the need for increasing subscriptions to the magazine. Mrs. Robert Zwicker, public relations chairman of the Kings Daughters of Appleton, talked on the Appleton Community Blood Center, Inc., expected to open in May.

A resolution stating that no unethical practices were being performed in the county at this time was approved. In addition, the polio immunization program was approved for the county. The society also approved the proposal that the county coroner be a licensed physician.

Pierce–St. Croix

At the regular monthly meeting of the Pierce–St. Croix County Medical Society on March 15 at New Richmond, Dr. Leo A. Nash and Dr. Charles T. Eginton of St. Paul were the guest speakers.

X-ray interpretation in the diagnosis of acute surgical conditions of the abdomen was presented by Doctor Nash, and correlated surgical therapy was discussed by Doctor Eginton.

Final plans for the Student Health Conference held at Wisconsin State College, River Falls, on April 5 were formulated. *Dr. E. F. Hill*, Spring Valley, and *Dr. J. H. Armstrong* of New Richmond, the county chairmen for the polio vaccination program, summarized the work that has been done to date in preparation for the immunization of school children.

Polk

Members of the Polk County Medical Society and its Auxiliary met on March 17 at the Dalles House, St. Croix Falls, as guests of *Dr.* and Mrs. *L. J. Weller* of Osceola.

Dr. Charles T. Eginton and Dr. Leo Nash of St. Paul presented a symposium on "The Acute Abdomen." A round-table discussion followed.

Dr. W. C. Andrews of Frederic discussed the Salk vaccine program to be carried out in April. Three vaccination centers were tentatively assigned in the county.

Price–Taylor

Members of the Price–Taylor County Medical Society met on April 2 at the Leahy Clinic, Park Falls.

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Guest speakers from the Duluth Clinic, Duluth, and their subjects were:

Dr. R. O. Bergan—Intestinal Obstruction in Infants

Dr. J. J. Coll—Hypertension

Dr. Joe Fuller—Tracheotomy in Chest Injuries

Dr. H. G. Moehring—X-ray Diagnosis, Gravity in Gallbladder X-rays

Discussants were *Drs. J. L. Murphy* and *J. J. Leahy* of Park Falls and *Drs. J. L. Rens, W. E. Niebauer*, and *H. B. Norviel* of Phillips.

Richland

Members of the Richland County Medical Society heard an address by *Dr. Henry Suckle* of Madison at their monthly meeting on March 3 at the Richland Hospital Library in Richland Center. Doctor Suckle spoke on "The Treatment of Head Injuries."

Sauk

A joint meeting of the Sauk County Medical and Dental societies was held at the Warren Hotel, Baraboo, on March 15.

Dr. Stuart Kelly, Madison dental surgeon, spoke on "What is New in Exodontia." Fifteen physicians and 21 dentists were present.

On April 12, Mr. Paul Doege, sales coordinator of Wisconsin Physicians Service, and Mr. Robert Froehlke, assistant secretary of the Hardware Mutuals Insurance Company, presented a discussion on "The Doctor and Health Insurance."

Trempealeau–Jackson–Buffalo

On March 22, members of the Trempealeau–Jackson–Buffalo County Medical Society and their wives met at the Club Midway, just east of Independence, for a program presented by *Drs. C. O. Rogne* of Ettrick and *O. M. Schneider* of Blair.

On April 26, the physicians met at the Club Midway to hear a discussion of "Allergies in General Practice," presented by *Dr. R. E. McMahon* of La Crosse.

Walworth

On March 10, members of the Walworth County Medical Society heard an address by *Dr. Burton Waisbren* of Milwaukee on "The Use of Antimicrobial Agents."

The county society agreed to accept the program set up for immunization against polio, should the vaccine become available.

Dr. William H. Frackelton, plastic surgeon from Milwaukee, spoke to the members at their meeting in the Sterlingtonworth Hotel on April 14.

His subject was "Injuries to the Hand."

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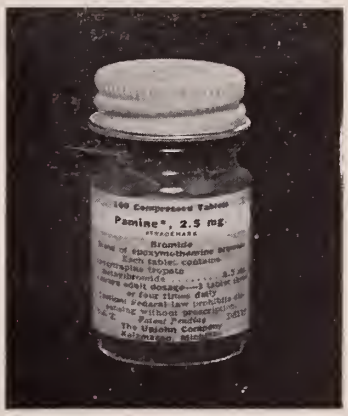

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Winnebago

Dr. R. C. Kory, assistant clinical professor of medicine at Marquette University School of Medicine, was the speaker at the April 7 meeting of the Winnebago County Medical Society held at the Athearn Hotel, Oshkosh. He discussed "Clinical Cardiac Problems" and "Cardiac Catheterization."

Fond du Lac Chapter, American Academy of General Practice

The Fond du Lac chapter of the American Academy of General Practice met on April 7 at the Elks Club, Fond du Lac, and heard a talk by Dr. John Rankin of the neurology department at the University of Wisconsin. He spoke on "Management of the Cerebrovascular Accident." Following his talk, members participated in a question-and-answer period.

Milwaukee Oto-Ophthalmic Society

Dr. Donald Hughson, Milwaukee, and Merle Lawrence, Ph. D., of the Institute of Industrial Health, University of Michigan, were speakers at the March 22 meeting of the Milwaukee Oto-Ophthalmic Society. Doctor Hughson's topic was "Polyethylene Tract in Cyclodialysis," and Doctor Lawrence discussed "Function of the Middle Ear."

Milwaukee Society of Anesthesiologists

New officers were elected at the meeting of the Milwaukee Society of Anesthesiologists held at the Milwaukee Athletic Club on April 11. *Dr. J. W. Bookhamer* was named president of the group, with *Dr. R. R. Brazy* as vice-president. *Dr. J. M. Beffel, Jr.*, was elected secretary-treasurer.

The April 11 meeting concluded the third year of existence of this society, a group made up of anesthesiologists from Milwaukee and the surrounding area.

Milwaukee Academy of Medicine

Meeting at the University Club on April 19, members of the Milwaukee Academy of Medicine heard a talk by Charles M. Pomerat, Ph. D., Professor of Cytology at the University of Texas Medical School, Galveston, Texas. His topic title was "Dynamic Cytology in Experimental Medicine."

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Wisconsin Surgical Society

The semiannual meeting of the Wisconsin Surgical Society was held at St. Luke's Hospital, Racine, on Saturday, April 16. More than 100 Wisconsin surgeons attended.

Dr. Sigurd Gundersen, La Crosse, was installed as president of the group. Other new officers are *Dr. T. J. Snodgrass*, Janesville, president-elect, and *Drs. J. A. Killins*, Green Bay, and *J. E. Conley*, Milwaukee, members of the council. *Dr. J. M. Sullivan*, Milwaukee, continues as secretary-treasurer.

The morning session, presided over by *Dr. R. M. Kurten*, Racine, was devoted to case studies and papers by Racine surgeons. Among those participating were *Drs. L. E. Fazen, Jr., F. M. Hilpert, C. W. Christenson, W. J. Madden, G. W. Gillett, R. B. Leitschuh, E. W. Schacht, and H. J. Barina.* Operative clinics to demonstrate new techniques and particular problems were also a part of the morning program.

In the afternoon, papers were given by the following physicians from other parts of the state: *L. W. Tasche*, Sheboygan; *R. H. Lillie*, Milwaukee; *J. M. King*, Milwaukee; *F. Gregory Connell*, Oshkosh; *N. E. Bear*, Monroe; *C. M. Schroeder*, Milwaukee; *A. G. Martin*, Milwaukee; and *L. E. Holmgren*, Madison. This session was presided over by *Dr. Frank Weeks*, Ashland.

Dr. Robert Myers, executive assistant to the secretary-general of the American College of Surgeons, gave the address at the banquet held at the Hotel Racine on Saturday night. He spoke on "Surgical Ethics and Economics."

Milwaukee Neuro-Psychiatric Society

Members of the Milwaukee Neuro-Psychiatric Society met on Wednesday, April 20, at Mendota State Hospital, Madison. Speakers at the scientific session were V. Terrell Davis, M. D., Clinical Director, Wisconsin Diagnostic Center, who spoke on "The Development of the Clinical Program at the Wisconsin Diagnostic Center," and *E. M. Burns, M. D.*, former clinical director, Mendota State Hospital, whose topic was "A Report on Five Cases of Exhibitionism: Clinical and Dynamic Aspects."

Before the scientific program, members met for a social hour at the residence of *Dr. W. J. Urben*, superintendent of Mendota State Hospital. A dinner and business meeting also preceded the program.

Wisconsin Surgical Club

From February 27 to March 5, twenty members and guests of the Wisconsin Surgical Club made their annual spring tour, which this year covered the principal surgical centers in Ohio.

They were guests of Dr. William A. Altmeier, chairman of the surgical department of Cincinnati University Medical School for two days. On Monday, February 28, they attended surgical clinics and a program at the Cincinnati General Hospital; and Tuesday was spent at the Veterans Hospital, where

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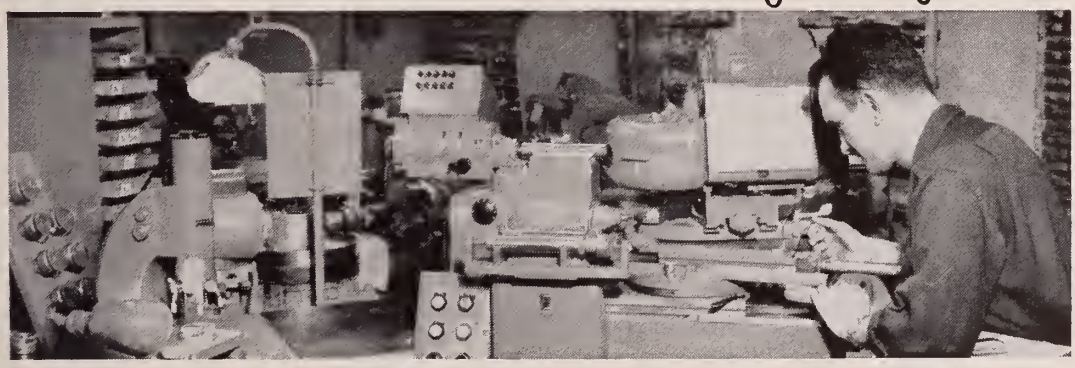

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surgical clinics and a pathological conference were held. On Monday evening the group entertained Doctor Altmeier and his staff at a dinner at the Netherland Plaza Hotel.

In Columbus, the physicians met with the Columbus Surgical Society for a dinner and program and attended programs and discussions presented at the University Hospital. Dr. R. M. Zollinger was host to the group.

During their visit to Cleveland, they were guests of Dr. George Crile, Jr., and Dr. R. S. Dinsmore and staff at the Cleveland Clinic and Hospital. Discussions, operative clinics, a panel discussion on "Limitations of Surgery in Treatment of Cancer," and a dinner at the Hotel Cleveland were features of interest.

Western Reserve University School of Medicine was visited on Friday, March 4. Dr. William D. Holden, chairman of the surgical department, and members of his staff were hosts to the group. Dr. Claude S. Beck and associates presented a discussion on the surgical management of coronary artery disease, and surgical clinics were held and operations performed. In the afternoon, various members of the staff presented papers covering a wide range of subjects including both clinical and research problems. A buffet dinner under the preparation of *Dr. Russell Kurten* was served following the scientific program.

Guests who accompanied the club on the tour were *Drs. H. T. Gross*, Appleton; *A. G. Martin*, Milwaukee; *J. R. Steeper*, Madison; *L. D. Graber*, Oshkosh; *C. M. Schroeder*, Milwaukee; *J. M. Sullivan*, Milwaukee, *J. A. Killins*, Green Bay; and *N. O. Becker*, Fond du Lac.

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News Items and Personals

Sparta Physicians Attend Postgraduate Courses

Dr. E. O. Lukasek attended a course in Internal Medicine and Diabetes on March 29, 30, and 31. This postgraduate course was held at the University of Wisconsin General Hospital, Madison.

Drs. J. D. Brown and *D. C. Beebe* recently attended courses at Cook County Hospital, Chicago. Doctor Brown took a two-week course in heart disease, and Doctor Beebe attended a course on colon surgery.

Doctor H. J. Heath Honored

Dr. H. J. Heath, Juneau, was given an honorary membership in the Dodge County Chapter of the National Association of Power Engineers at a banquet held in the Horicon American Legion Building on February 22. This presentation was in accordance with the national association's request that local chapters honor an outstanding man of science in their own communities during National Engineers Week, February 20–27.

Doctor David Werner Opens Office in Sheboygan

Dr. David A. Werner, a 1953 graduate of the University of Wisconsin Medical School, has announced the opening of his office for the general practice of medicine in Sheboygan. Doctor Werner received his Bachelor of Science degree from Georgetown University, Washington, D. C., in 1949, and he interned at Sacred Heart General Hospital, Eugene, Oregon.

Lake Geneva Physician Enters Service

Dr. H. F. Bischof, Lake Geneva, reported to Gunter Air Force Base, Montgomery, Alabama, on April 4. He entered service with the rank of major. After completing six weeks of orientation, he will be assigned to a permanent post. It is expected that he will be in service for two years.

Doctor Bischof has been at Lake Geneva for the past 10 years. He received his M. D. degree from the University of Chicago in 1942 and had practiced for two years at Richland Center before coming to Lake Geneva.

Doctor McMahon Attends Postgraduate Course

Dr. A. E. McMahon, Menomonie, was in Minneapolis attending a postgraduate course in emergency surgery on March 31–April 2. The course was held at the Center for Continuation Study at the University of Minnesota.

Fennimore Physician Moving Into New Clinic

Dr. C. H. Shields, Fennimore, has announced that he is moving into a new, modern clinic. The new building has six rooms—two examination rooms, an emergency room, x-ray room, laboratory, and therapy room.

Dr. Robert Taylor Addresses Marshfield Rotary Club

Dr. Robert Taylor, Marshfield, addressed the local Rotary Club on April 11. He explained the program formulated by the American Heart Association seven years ago to combat heart disease and told of the efforts to raise funds for vital research in this field and of the progress made thus far. He described surgical procedures devised to remedy some heart defects and injuries and told of the new drugs developed to aid heart sufferers. He expressed the hope that Marshfield might be further developed as a medical center that would contribute to the attack on cardiovascular disease.

Coming to Marshfield on January 1, Doctor Taylor was previously associated with the Cleveland Clinic. He is a director of the American Heart Association and chairman of the American Medical Association's section on experimental medicine.

Doctor Hildebrand Honored

Dr. W. B. Hildebrand, Menasha, outgoing president of the American Academy of General Practice, was honored at a luncheon attended by the Wisconsin delegation on March 30. Dr. John S. Detar of Milan, Michigan, the president-elect of the Academy for 1956, was also present at the luncheon; and others attending were film star Pat O'Brien and Elroy Hirsch, Wausau, former University of Wisconsin and professional football player.

Doctor Klaas Moves Into New Office

Dr. F. B. Klaas has moved into a new office in East Ellsworth. His new quarters include a reception room, private office, two examining rooms, an x-ray room, baby room, drug room, and laboratory.

Doctor Sahs Associates with Hayward Clinic

Dr. M. H. Sahs, who has been at Spooner for the last six years, recently became associated with *Drs. D. H. Callaghan* and *E. R. Krueger* at the Hayward Clinic.

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He is a graduate of the University of Iowa College of Medicine, and interned at Pennsylvania Hospital, Philadelphia. He was an army physician during World War II and after the war was resident physician in neurology at the University of Iowa.

Former Waupun Physician Continues Residency in Virginia

Dr. J. P. Semmens is completing his first year of residency in obstetrics and gynecology at the Naval Hospital, Portsmouth, Virginia, and has been appointed for his second year. He will be in Portsmouth through June 1956.

Doctor Salter in California

Dr. R. K. Salter is now located in Stockton, California, and is engaged in the practice of general and thoracic surgery. Before going to Stockton, he was at the Surgical Service of Wm. Beaumont Army Hospital, El Paso, Texas, where he was assistant chief of general surgery. He had been stationed there for nearly two years.

In January 1954 Doctor Salter became a Diplomate of the American Board of Surgery.

THIRD AND TWELFTH DISTRICTS NEWS

Doctor Curreri Attends Out-of-State Medical Meetings

Dr. A. R. Curreri, Madison, recently attended a medical meeting in Pocatello, Idaho. On April 13 he went to San Francisco for a meeting of the American Association for Cancer Research.

Doctor Reznichek Delegate to AAGP Convention

Dr. C. G. Reznichek, Madison, was the Wisconsin delegate to the March 26–31 national convention of the American Academy of General Practice held in Los Angeles. He is a past president of the Wisconsin chapter.

Other Madison physicians attending were *Drs. J. G. Waddell* and *J. G. Van Gemert.*

Multiple Sclerosis Society Opens Headquarters

The Multiple Sclerosis Society of Milwaukee has opened headquarters in Room 521 of the Caswell Building, 152 West Wisconsin Avenue, Milwaukee. Miss Hedwig Poehler, a social worker who has been appointed executive director, will have close contact with multiple sclerotic patients and their families, help adjust personal problems, give a limited type

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of counseling and supportive service, assist with interpretation where indicated, and work for additional community services. She can be of assistance to physicians by serving as a clearing house for information about resources in the community which give assistance with problems created by the presence of chronic disease in the home.

The society arranges meetings where patients may meet each other and discuss their common problems, their ways of adjusting to their situation, their new interests and hobbies. Speakers are provided for these meetings. A newsletter, giving information about the society's activities and emphasizing the availability of known therapy in Milwaukee, is also published by the organization.

Doctor Veit Speaks in Hawaii

Dr. Henry Veit, Milwaukee, recently returned from Hawaii, where he gave two lectures. On Tuesday, March 8, speaking for the Pupil Guidance Service and The Mental Health Association in the auditorium at the Queen Liliuokalani Building, he discussed "Physiological and Psychiatric Aspects of the Slow Learner." On March 10, he lectured on "As a Psychiatrist Looks at Mental Deficiency and Epilepsy," for the Mental Health Association and the Hawaii Association to Help Retarded Children.

Madison Pediatric Society

On Tuesday, March 29, the Madison Pediatric Society presented a lecture by R. L. Faucett, M. D., Consultant, Section on Psychiatry, Mayo Clinic. Doctor Faucett discussed "The Relationship Between Child Psychiatry and Internal Medicine."

University of Wisconsin Medical School Society

Dr. J. Dixon Boyd, Professor of Anatomy, Cambridge University, Cambridge, England, was the speaker at the March 28 meeting of the Medical School Society at the University of Wisconsin. He lectured on "Pigment Cells and Their Significance in Human Embryos."

Wisconsin Student Medical Association

Members of the Student Medical Association at the University of Wisconsin heard an address by Mr. Steven Gavin, attorney at law, on Wednesday, April 6. Mr. Gavin discussed "Cult Practitioners in Wisconsin."

Medical School Fraternities Present Lectures

"Joint Fluid Changes Induced by Systemic and Local Administration of Steroids," a lecture by Dr. Ivan F. Duff, Associate Professor of Medicine and Director of the Rackham Arthritis Research Unit at the University of Michigan Medical School, was presented by Alpha Omega Alpha on Thursday, March 24.

On April 21, the Phi Delta Epsilon fraternity sponsored a lecture by Louis N. Katz, M. D., Director of Cardiovascular Research at Michael Reese Hospital, Chicago. He spoke on "Hormonal Regulation of Atherosclerosis."

MARRIAGES

Dr. R. M. Block, Kenosha, to Janet Lee Downs, Wilmette, Illinois, March 19.

SOCIETY RECORDS

New Members

W. J. Schutz,* 308 West Green Bay Street, Shawano.

C. H. Mahaffey,* 231 East La Salle Avenue, Barron.

A. A. Teitgen,* 927 South Eighth Street, Manitowoc.

J. B. Miale,* Jackson Memorial Hospital, Miami, Florida.

C. I. Siefert, Oconto Falls.

J. H. Young,* Elkhorn.

Chalmer Davee, Veterans Administration Center, Hot Springs, South Dakota.

W. A. Domann, 206 Theodore Avenue, Menomonee Falls.

M. J. Watunya, 318 Main Street, La Crosse.

J. E. Garritty, Antigo.

M. E. Royce,* 105 Bridge Street, Mayville.

N. W. Erickson, 176 Oak Street, Juneau.

David E. Vig, 122½ South Main Street, Viroqua.

C. E. Ward, 110 North Durkee Street, Appleton.

J. N. Bonner, 103 West College Avenue, Appleton.

T. M. Loescher, 120 South Oneida Street, Appleton.

W. E. Rosenkranz, Eagle.

W. J. Blake, Waters Court, Elm Grove.

M. E. Carroll, 5417 North 64th Street, Milwaukee.

H. M. Cutting, 2137 West National Avenue, Milwaukee.

John Bareta, 500 West Chambers Street, Milwaukee.

Stanley Berlow, 1513 East Capitol Drive, Milwaukee.

R. W. Boyle, Marquette University School of Medicine, Milwaukee.

C. H. Dowding, Jr., 4410 West Roosevelt Drive, Milwaukee.

R. F. Madden, 2931A North 38th Street, Milwaukee.

K. D. Epperson,* 324 East Wisconsin Avenue, Milwaukee.

R. D. Taylor, 512 St. Joseph Avenue, Marshfield.

J. H. Holman, 310 Fifth Street, Racine.

A. G. Britt, 212 South 11th Street, La Crosse.

Mary B. Scheurich, 212 South 11th Street, La Crosse.

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

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Brown, H. W.: J. Pediat. 45:419, 1954.

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R. E. Hunter, Argyle.

J. L. Claude, 114 Wisconsin Avenue, Oconomowoc.

T. S. Arnold, 826 North Eighth Street, Manitowoc.

H. J. Conlon, 310 Chestnut Street, Eau Claire.

P. E. Sadler, 2930 Barlow Street, Madison.

R. B. Ainslie, 16 South Henry Street, Madison.

Alice R. McPherson, 1300 University Avenue, Madison.

J. F. Morrissey, 2419 Norwood Place, Madison.

C. J. Wheeler, Jr., 1300 University Avenue, Madison.

Jeanne Anderson, 1300 University Avenue, Madison.

F. L. DeGroat, Jr., 7400 West Center Street, Milwaukee.

M. J. Denio, Jr., Veterans Administration Hospital, Wood.

A. L. Settimi, Milwaukee County Hospital, Milwaukee.

G. H. Stannard, Jr., 1011 North Eighth Street, Sheboygan.

J. L. Weygandt, 118 Pine Street, Sheboygan Falls.

E. D. Wipperman, 1011 North Eighth Street, Sheboygan.

A. J. Pace, R.F.D. 2, Eagle River.

H. W. Taylor, Jr., Box 593, Cuba City.

W. W. Chandler, 215 West Lawrence Street, Appleton.

T. E. Boston, Hillsboro.

D. A. Werner, 1424 Union Avenue, Sheboygan.

T. S. Westcott, 115 West Chestnut, Pardeeville.

Changes of Address

D. T. Schuele, Madison, to Summit Hospital, Oconomowoc.

D. F. Watzke, % P.M., Seattle, to 130 Lathrop Street, Madison.

J. S. Altman, Kenosha, to Veterans Administration Hospital, Downey, Illinois.

R. H. Pfeifer, Birmingham, Alabama, to 162 37th Avenue, San Mateo, California.

M. S. LeTellier, Milwaukee, to 109 East Walnut Street, Green Bay.

J. E. Nilles,** Fort Sheridan, Illinois, to Det. 2, 5012 A.S.U., Camp Haven, Wisconsin.

T. L. Buhl,** Travis A.F.B., California, to 16422 Ventura Boulevard, Encino, California.

C. F. Sherman, Madison, to Veterans Administration Center, Temple, Texas.

W. S. Middleton, Madison, to Veterans Administration, Washington, D.C.

J. P. Semmens,** Port Chicago, Illinois, to U. S. Naval Hospital, Portsmouth, Virginia.

J. M. Schroeder, Madison, to Winnebago State Hospital, Winnebago.

W. E. Mateicka, Milwaukee, to 1601 Summit Avenue, Warren Heights, Cheyenne, Wyoming.

W. K. Hoffman, Milwaukee, to Apartment 3, 509 South 42nd Street, Philadelphia, Pennsylvania.

A. B. Weinstein,** Madison, to General Delivery, MFSS, BAMC, Fort Sam Houston, Texas.

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For information about these and other courses address: THE DEAN, 345 West 50th Street, New York City 19

DEATHS

Dr. Carl Edward Zellmer, 61 years of age, died on March 15 as the result of injuries sustained in an automobile accident near Compton, Illinois, four hours earlier.

C. E. ZELLMER

Born in Antigo on January 12, 1894, he received his preliminary education in the Antigo schools. He attended the University of Wisconsin Medical School; Northwestern University Medical School, Chicago; and the University of Pennsylvania School of Medicine, Philadelphia, receiving his medical degree from the last-named school in 1919.

During World War I, he served in the Medical Corps of the American Red Cross during his school period; and from 1920 to 1921 he was a bacteriologist at the University of Wisconsin Hospital in Madison. He also served as assistant pathologist at the University of Wisconsin Medical School during the latter period.

In 1922 he started his medical practice in Antigo, where he had continued until his death. Doctor Zellmer and his family were returning from a meeting of the New Orleans Medical Assembly in New Orleans, Louisiana, when they had a head-on automobile collision near Compton.

Doctor Zellmer had served as secretary of the Langlade County Medical Society, as a delegate and alternate delegate to the House of Delegates of the State Medical Society from his county society, member of the Committee on Grievances of the State Medical Society, and councilor of the Thirteenth Councilor District of the State Society.

He became a member of the Dane County Medical Society in 1920 and transferred his membership to Langlade County in 1922. He had been a continuous member of the State Society and the American Medical Association since 1920.

He is survived by his widow, Lillian; their two children, Lindy and Thomas; and three children by a previous marriage, Mrs. Emily Schroeder of Monroe, Winifred and Julie of Antigo. A son, Carl Thomas, died in 1925 at the age of two years.

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Dr. Bjarne Ravn, radiologist at Merrill, died on April 11. Born at Scandinavia, Wisconsin, on November 25, 1884, he was 70 years of age at the time of his death.

He attended Northwestern University Medical School, Chicago, from which he graduated in 1908. He had previously attended the University of Wisconsin Medical School for two years.

From 1908 to 1910 he was located at Merrill, then moving to Melroy, Minnesota, where he remained until 1917. From 1917 to 1920, he practiced at Windom, Minnesota, and from 1920 to 1924 at Minneapolis. In 1924 he returned to Merrill to practice until his death.

Doctor Ravn was a member of the Lincoln County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He was a member of the Radiological Society of North America and in recent years limited his practice to radiology.

He was associated with his brother, Dr. Erling, in the operation of the Ravn Clinic, founded by their late father, Dr. Michael, and served as radiologist at Holy Cross Hospital, Merrill; Langlade Memorial Hospital, Antigo; and Fairview Hospital, Ironwood, Michigan.

Doctor Ravn had served as president of the Lincoln County Medical Society and as president of the Eleventh District Medical Society.

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He is survived by his widow, Myrtle; a daughter, Mrs. Walter Roemer of Medford, Oregon; his brother, Dr. Erling; and three sisters, Mrs. Agnes Bache-Wing of Waukesha, Mrs. Signe Wing of Pasadena, California, and Miss Valborg Ravn of Anoka, Minnesota.

Dr. Dennis Henry Bruns, former Wisconsin physician, was killed March 10 when the airplane he was piloting struck some wires and crashed. The accident occurred outside Phoenix, Arizona.

Born on April 15, 1889, in Buke, Westphalia, Germany, Doctor Bruns received his medical degree in 1914 from the University of Heidelberg, Germany. He served his internship at the University Hospital at Heidelberg and was a resident at the hospital at Hoexter Duesseldorf, Bonn, from November 1919 to January 1924.

Doctor Bruns practiced at Watertown, Wisconsin, from January 1925 to November 1930 and in Milwaukee from 1931 to 1952, when he moved to Camarillo, California. Early in 1954 he moved to Phoenix, Arizona, and had intended to return to Milwaukee this year.

Doctor Bruns is survived by a brother and sister living in Germany.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

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Surgical Anatomy & Clinical Surgery, Two Weeks, June 20
Surgery of Colon & Rectum, One Week, June 13
General Surgery, One Week, May 23, October 17
Gallbladder Surgery, Ten Hours, June 27
Thoracic Surgery, One Week, June 6
Esophageal Surgery, One Week, June 13
Fractures & Traumatic Surgery, Two Weeks, June 20

GYNECOLOGY—Office & Operative Gynecology, Two Weeks, June 13
Vaginal Approach to Pelvic Surgery, One Week, June 6

MEDICINE—Two-Week Course, September 26
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Hematology, One Week, June 13

RADIOLOGY—Clinical Diagnostic Course, Two Weeks, by appointment
Radium Therapy, One Week, May 23
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Dr. William Parker Finney, 66 years of age, died on March 29 at Lake Geneva, following an illness of 10 years.

He was born January 20, 1889, in New Egypt, New Jersey, and received his medical degree from Johns Hopkins University School of Medicine, Baltimore. He practiced for 12 years at the Mayo Clinic, Rochester, Minnesota, and in Winnetka, Illinois, and Chicago. In 1945 he established permanent residence at Lake Geneva.

Survivors include his widow, Theodora; three daughters, Pamela of Lake Geneva, Mrs. Theodora Lippett, Savannah, Georgia, and Mrs. Ellen Jones, Wilmette, Illinois; and two sons, William P., III, Cleveland, Ohio, and Samuel, Lake Geneva.

Dr. Walter J. Olsen, formerly of Sturgeon Bay, passed away on April 2 in Escanaba, Michigan, at the age of 47 years.

Born July 27, 1907, in Langlade County, he received his medical degree from Marquette University School of Medicine, Milwaukee, in 1937. He served his internship at Misericordia Hospital, Milwaukee, and practiced at Sawyer and Sturgeon Bay before moving to Michigan in July 1954.

He was a former member of the Brown–Kewaunee–Door County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Joyce; two sons, Erich and Walter, Jr.; his mother, Mrs. Jennie V. Olsen, Seymour; three sisters, Mrs. Carl Mielke, Seymour, and Mrs. Bernard Poff and Mrs. Carl Erennecke, Mosinee; and a brother, Harry, Antigo.

Dr. Judd Dow Fuller, 69 years of age, died on April 12 at his home in Lomira, Wisconsin.

Born in 1886, he was graduated from Marquette University School of Medicine in 1910. He practiced at Plaza, North Dakota, from 1910 until 1923; at Brownsville, Wisconsin, from 1923 to 1935; and at Lomira from 1935 until his death.

He was a member of the Fond du Lac County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Doctor Fuller is survived by his widow; two daughters, Mrs. Walter Zimmerman, Beaver Dam, and Mrs. LaVern Bernel, Duluth, Minnesota; two grandchildren; and a brother, Dr. Maynard Fuller, Green Bay physician.

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WANTED: Associate to general practitioner with active practice grossing well over $40,000. To start on liberal percentage basis; eventual partnership. No financial investment. New clinic-type building. Hospital staff appointments assured. Write full particulars in first letter. Address replies to Box 575 in care of the Journal.

WANTED: General practitioner for rural community. Large practice, grossing $20,000 per year. Large, modern, fully equipped office with laboratory, including G. E. x-ray with fluoroscopy, new G. E. diathermy and E. C. G. equipment. Available on extremely liberal terms. Previous physician now in medical research. Young dentist and pharmacist in same building. Address replies to Mr. Edward Kraemer, Plain, Wis.

WANTED: Psychiatrists or young doctors interested in psychiatry to work at Mendota State Hospital. Positions permanent and under Civil Service. Salary dependent upon previous experience and training. Housing available on grounds. Contact Dr. W. J. Urben, Superintendent, Madison 4.

WANTED: Midwest medical group desires association with young man to serve as surgical assistant. Position available July 1. Address replies to Box 586 in care of the Journal.

WANTED: Young M. D. wishing to do independent general practice. Present practice available for cost of general office equipment only. Owner leaving to specialize. Location, Janesville, Wis., population, 28,000. Excellent hospital. Pleasant office space available. Write G. P. Gredler, M. D., 305 Court Street, Janesville, Wis.

WANTED: Associate in southern Wisconsin college city of 35,000. General practice with interest in surgery and obstetrics. Address replies to Box 590 in care of the Journal.

WANTED: Physician to take over practice of owner who expects to enter military service in near future. Community of 2,300 with hospital facilities nearby. Equipment may be purchased. Possibility of association following service. Address replies to Box 596 in care of the Journal.

WANTED: New or used ether suction anesthetic machine, cabinet model, erosion proof. Phone or write M. Margoles, M. D., 1971 W. Capitol Drive, Milwaukee, Wis.

PHYSICIANS WANTED: The Mendota State Hospital has temporary staff positions available for young doctors awaiting military or residency assignments. Contact Dr. A. Soucek, Assistant Superintendent, Mendota State Hospital, Madison 4, Wis.

WELL-TRAINED ASSOCIATE WANTED to assist established, busy physician in North Shore suburb of Milwaukee. Attractive modern offices completely equipped with modern diagnostic and therapeutic equipment. Three medical assistants, including laboratory technician. Good salary on incentive basis and eventual partnership; excellent opportunity. Phone Woodruff 2-8000 or write 5630 North Lake Drive, Whitefish Bay, Wis.

PHYSICIAN-SURGEON WANTED for industrial community serving 3,000 people within 20-mile area. Will lease attractive doctor's residence and fully equipped first-aid hospital for private practice. Estimated net income of $10,000 for first year, and practice should increase each year thereafter. Available for immediate occupancy. Phone or write Goodman Lumber Company, Goodman, Wis.

TWO GENERAL PRACTICE RESIDENCIES AVAILABLE JULY 1: Six months, medicine and pediatrics, and six months, surgery and obstetrics. At the Monroe Clinic and the St. Clare Hospital, Monroe, Wis. 160-bed hospital. Opportunity for locating in area after completing residency. Stipend, $300 plus allowances. Must have or be eligible for Wisconsin license. Contact Harold E. Scherer, Business Manager, The Monroe Clinic, Monroe, Wisconsin.

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OB-GYN board-qualified specialist desires to locate in Wisconsin; interested in partnership, association, or clinic practice. A 1947 graduate of the University of Wisconsin Medical School. Address replies to Box 594 in care of the Journal.

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FOR SALE: Combination house, office, and practice. Excellent location in north central Wisconsin, in territory including several towns and villages without a doctor. Practice established over 20 years. Modern home and office; office completely furnished. Civic groups will give support. Owner selling because of age and poor health. Address replies to Box 587 in care of the Journal.

FOR SALE BY WIDOW OF PHYSICIAN: Modern residence, with doctor's office and waiting room, located at 1387 Main St., Marinette, Wis. 3-car garage building. Ideal location for doctor wishing to succeed to well-established practice. Write Mrs. Stella Schroeder, 1387 Main Street, Marinette, Wisconsin.

FOR SALE: Milwaukee general practice, established for 30 years, grossing $20,000. Available June 1 for price of equipment. Stipend guaranteed. Owner is specializing. Address replies to Box 593 in care of the Journal.

FOR SALE: 60 MA x-ray complete with table and equipment; Hanovia ultraviolet lamp; 5 horsepower General Electric air conditioner; mahogany desk and chair; steel desk; and waiting room furniture. All in good condition. Write Dr. E. M. Kay, 3323 N. Green Bay Ave., Milwaukee 12, Wis.

FOR RENT: Office space for physicians in modern, air-conditioned, three-story professional building with elevator. Contact R. H. Lehner, M. D., 312 Seventh St., Racine, Wis.

FOR SALE: Property of recently deceased Wisconsin physician and surgeon in desirable, prosperous rural community. Modern hospital facilities available. Property includes brick home, office facilities, and two-car brick garage. Lot is approximately 80' by 180'. Office equipment, instruments, etc., if desired. Financing available. Address replies to Box 597 in care of the Journal.

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FOR SALE: Well-established general practice in thriving community four miles from the Milwaukee southwest city limits. Attractive brick home and office. Hospital facilities available. Address replies to Box 599 in care of the Journal.

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THE WISCONSIN MEDICAL JOURNAL

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Volume 54 JUNE 1955 Number 6

Message to the House of Delegates*

By E. L. BERNHART, M. D.
Milwaukee

THIS morning I was in receipt of a telegram which was addressed to me, conveying the wishes of the individual, and I would like to read it to you:

"May I convey my warmest personal greetings to the assembled members of the State Medical Society. It will be a pleasure to hear from you on all ways and means by which I can be of service to you and your great organization. /s/ Alexander Wiley, Senator from Wisconsin."

I have been a member of this body for nearly 15 years, and it is with great respect that I accept the office of President of the State Medical Society of Wisconsin. There are some of you in this House of Delegates who were members before I was graduated from medical school, and it is you upon whom I will rely for guidance and advice. I will lean heavily upon your judgment in the coming year as president of this organization.

Having served as president-elect since last October and completing that term today, I am thankful for the fact that I have been given some respite in starting the first "short term," so to speak. However, the executive staff seems to have crowded a year's work into seven months—not without a penalty being paid by some. Earl Thayer, one of our assistant secretaries, has been sick in bed for several weeks. Mr. Hoops, our comptroller, has been hospitalized and is now recuperating. I must say that Charlie Crownhart is looking well, and it makes me wonder whether he works as hard as it sounds.

The new headquarters of the State Medical Society is now at last a reality. Everyone can be proud of this monument or, rather, I will say, of this workshop for our headquarters in Wisconsin. It is a fitting tribute to the efforts of the profession.

Wisconsin Physicians Service, the Blue Shield Plan of our State Society, is enjoying a successful year. Last year the income of the plan exceeded four million dollars. Benefit payments amounted to over three million dollars.

The Commission on Prepaid Plans continues to guide carefully our program. Experimental projects have been undertaken. A type of major medical contract was issued, and the Society has successfully negotiated reinsurance through traditional channels.

Surgical Care, the Blue Shield Plan of the Medical Society of Milwaukee County, continues to serve faithfully the purposes for which it was established. Over 415,000 people are enrolled at the present time.

The prepayment plans in Wisconsin have established themselves as leaders in the field. Expansion of coverage, growth in enrollment, and adherence to insurance principles are the basis for that leadership. Medical control will assure its continuation. Objections raised from time to time by those in and out of the profession must be met. We cannot stop, however, to meet all objections, for to do so would inhibit progress.

Blue Cross deserves congratulations in this its fifteenth year. Differences have arisen between Blue Cross and our State Society, and I assume that some differences will arise in the future. They shall be resolved to the credit of the profession, the hospitals, and the people whom we engage to carry out the basic philosophies which are expressed in these programs.

All problems must be faced with courage and the desire to accomplish that which will best serve the interest of the people who are our patients and our first obligation.

In 15 years Wisconsin Blue Cross has paid nearly 75 million dollars for hospital services. In the shorter period that Wisconsin Blue Shield plans have been functioning, they

* Presented before the House of Delegates, One Hundred Fourteenth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, May 3, 1955.

have paid 29 million dollars. Wisconsin Blue Cross presently has 900,000 people enrolled and, of these, 700,000 are enrolled in the Blue Shield plans.

Regarding Blue Shield and Blue Cross plans, a word should be said about the national picture. There are now 78 Blue Shield plans in the country, with 32,000,000 people enrolled. The Blue Shield Commission, composed of doctors and executives, represents the board of trustees of the various plans. Two members of the Commission are from Wisconsin; they are Dr. Paul Mason of Sheboygan and Mr. Jim Kelley of Milwaukee. The Commission has established a national insurance company called Medical Indemnity of America, Inc., and in conjunction with Health Service, Incorporated, and the Blue Cross Commission it has developed a national enrollment program. We are reminded by our watchful executive secretary to maintain our interest in these national movements.

The dramatic dividends of a career in medicine have been recently demonstrated in the development of the Salk vaccine. One hundred fifty-nine years ago this month Edward Jenner performed his first vaccination against smallpox and established the science of immunology. The introduction of the Salk vaccine is greatly enhanced in value in the complex society of modern times. Further developments in connection with the vaccine will result from this meeting, as it is one of the most important matters on our agenda.

In connection with research, our two great universities are conducting programs in medical and related fields which we can appraise with optimism. At Marquette here in Milwaukee, investigative work is being done in connection with nucleolytic enzymes and proteolytic enzymes, arteriosclerosis, leukemia and blood research, hemorrhagic shock, partition of cell salicylate in lymph and plasma, and pharmacological aspects of lymph.

The medical school of the University of Wisconsin is conducting research in all of its departments. Among the research projects are studies of: congenital cardiovascular abnormalities by cardiac catheterization, and the effect of surgical correction on these abnormalities; cardiac resuscitation following cardiac arrest or ventricular fibrillation; the effect of cortisone in diffuse pulmonary granulomatous lesions; treatment of migraine with Rauwolfia alkaloids; multiple sclerosis (effect of high B_{12} on HCl deficiency, diet, histamine, and sodium succinate, and evaluation of proteolytic enzymes); the metabolism of tumor resistance; the influence of cortisone on metabolism; infectious mononucleosis, etiology and epidemiology; and diagnosis and treatment of the cerebral palsied infant.

The postgraduate courses which have been offered by our two great medical schools have further enhanced the knowledge of busy men in the actual practice of medicine. A tip of the hat to them for their efforts and their continued interest.

The efforts of our profession are directed toward the relief of human suffering; the preservation of human life; and, to the extent we frail humans are capable, to the preservation of health. In these efforts we are aided by nurses, therapists, dieticians, hygienists, technologists, pharmacologists, and many others.

This year brought to fruition the Wisconsin Interprofessional Institute, sponsored by the State Medical Society and held in Madison in January. The following organizations participated in this institute:

- Wisconsin Conference of Catholic Hospitals
- Wisconsin Hospital Association
- Wisconsin Pharmaceutical Association
- Wisconsin State Dental Society
- Wisconsin State Nurses Association
- State Board of Dental Examiners
- State Board of Health
- State Board of Medical Examiners
- State Board of Pharmacy
- State Department of Nurses
- State Department of Public Welfare
- Marquette University School of Dentistry
- Marquette University School of Medicine
- University of Wisconsin Medical School

Bringing the representatives of these organizations together for informal discussion and for formal activity should bring about a better understanding, which can only result in greater accomplishments by all of those who take part and who bring their knowledge and particular abilities to be shared unselfishly in the interest of greater health facilities. We cannot understand the other fellow's problem until we know what it is. Ill will is bred of ignorance. Education, understanding, and interchange of thought will

improve the relationships between these professions.

The Wisconsin State Dental Society has just completed its annual meeting here in Milwaukee. I noted the other day that one of their objectives is the increased use of hospital facilities for dentistry. This is a new facet of the practice of dentistry and perhaps one with growing indications. The willingness of the medical profession to cooperate in working out a solution is assured.

Next month the Wisconsin Pharmaceutical Association will celebrate its seventy-fifth anniversary in Madison. Many problems related to the practice of medicine will be aired during its formal meetings. These closely related activities can be evaluated through our Interprofessional Institute and the mechanism which it has established.

The golf tournament of the Wisconsin State Medical Golf Association, which was held yesterday, was attended by 122 doctors. The change to the day before the scientific meetings begin was worked out as the least conflicting with the program of the State Society. Starting our Annual Meeting with relaxation and friendly intercourse helps to create the air of cooperation which some of you will recall has sometimes been lacking.

I am desirous of delivering one more message, which has to do with accident prevention, the theme of Child Health Day, which was Sunday, May 1. In the last five minutes, somewhere in the United States 100 persons were injured more or less seriously, and at least one person was killed in an accident. Accidents account for about 7 per cent of the total deaths in this country each year—and most, if not all, are preventable. There are about ten million disabling injuries every year. More than half of these are caused in the home. The current "Do-It-Yourself" craze is adding to the toll.

This doesn't apply to all segments of our population. Of course, one form of prevention is to do nothing; then nothing can happen. Accident prevention should begin in our own homes. Every family we treat should be made aware of precautions to take and of the necessity for being careful.

Occupational injuries are on the decrease, but those of us who are interested in industrial medicine realize that great strides still can be made. I mention this phase of the practice of medicine because I feel too many disregard its importance and fail to appreciate the great good that can be so easily and dramatically accomplished if we will all invest the effort.

The president of the State Society is always dependent upon the cooperation and help from the men who serve on the various committees. It is actually they who do the majority of the work. It is the committeemen and the chairmen of the committees who shoulder the burden, who do the investigating, and who sit through the interminable meetings and make the recommendations that are eventually acted upon.

In closing, may I beg of you your assistance and spiritual guidance in order to keep this Association in its rightful place as the leader of organized medicine.

FILM ON CLEFT PALATE CHILD AVAILABLE

A new movie, "The Wisconsin Cleft Palate Story," in sound and color, has been produced by the Bureau for Handicapped Children, Department of Public Instruction, in cooperation with the University of Wisconsin Medical School, Department of Speech, and University Hospitals. It shows the integration of services necessary in the habilitation of a cleft palate child. This 36-minute film tells the story effectively and honestly.

The film can be rented from the Bureau of Visual Instruction, University of Wisconsin, 1323 West Johnson Street, Madison, Wisconsin, for a nominal fee. It is available for purchase through the Photographic Laboratory, 1204 West Johnson Street, University of Wisconsin Extension Division, Madison, Wisconsin.

The Patient-Physician Relationship*

By WILLIAM S. MIDDLETON**
Washington, D. C.

"THE art consists in three things—the disease, the patient and the physician. The physician is the servant of the art, and the patient must combat the disease along with the physician." This relationship is as vital to good medical practice today as it was when Hippocrates expounded it 400 years B.C. Since the accepted thesis implies a bilateral responsibility, its logical analysis must begin with an objective survey of the respective places of the contracting parties. If we begin with the patient we may assume that disquieting or disabling symptoms have led him to seek the professional service of a physician. From this moment a chain reaction is initiated which may result in the closest rapport or, conversely, in misunderstanding and recrimination.

Let us view the patient from a detached standpoint. Beset by unfamiliar evidences of disordered function, he seeks the advice of a physician. We trust that this medical counselor may establish easy rapport since the patient is constitutionally a selfish individual. Essentially introspective, the patient becomes very egocentric in the presence of pain or less obvious symptoms, to which he naturally ascribes the most serious explanation. Of course, there are notable exceptions to this major tenet. In fairness to the thousands of sufferers who bear adversity, pain, and disability bravely, may I say I wish their fortitude and forbearance might have a wider audience than the devoted families and physicians who gain inspiration and strength from their glowing examples. Whatever may be the factors involved, Parkinson strikes the proper note when he says, "Confidence is the hallmark of the good patient." The very existence of this sense of dependence constitutes a sacred trust to the medical profession. As Parkinson states, "Truly the best (patients) will keep faith when things go wrong, and what a stimulus that firm trust can be." Indeed, to the conscientious physician, its implied ramifications may be almost overwhelming.

The physician, as a party of the second part, has been born to a life of human service. His adjustments to the individual psychology are the reflection of a natural acceptance of his role as an adviser. Appreciating the profound concern of the patient, he will avoid any attitude or expression that may augment or fix fears. Whatever may be his natural reaction to a grave situation, he will steel his nerve and discipline his vasomotor and facial controls to dissemble his concern. Remembering that the patient is basically a human being, he will maintain those contacts that reflect his immediate personal interest. However profound may be his scientific background, the physician will do well to remember that patience, sincere kindliness, and forbearance will weigh much more heavily in the balance of reciprocal understanding than the most comprehensive knowledge of isolated scientific data. Parkinson expressed this thought, " 'And whosoever shall compel thee to go a mile, go with him twain.' The good physician will accompany his patient on the second mile and to the end of the road." As John Brown wrote, "that gentleness and compassion for his suffering fellow-men without which no man need hope to be a great physician."

Obviously, the traditional patient–physician relationship has undergone a serious deterioration within recent years; but the movement is not new. Superficial observers have found medicine an easy prey through the ages. Voltaire wrote, "A physician is one who pours drugs of which he knows little into a body of which he knows less." In a more constructive vein, Plato said, "For this is the great error of our day in the treatment of the human body, that physicians separate the soul from the body." This theme is repeated in the quotation from the contemporary Eduard Rist, "How many errors have been committed because the physician has not been able to discern, behind the masque of the invalid, a man." Although the

* From the Department of Medicine, University of Wisconsin Medical School.

** Chief Medical Director, Veterans Administration. Former dean, University of Wisconsin Medical School.

feckless rantings of self-appointed judges, without and within the profession, have shaken the temple of medicine from time to time, certain events suggest an augmentation of discord and a perceptible weakening of the public support of medicine within recent years. Significantly, many serious students of the subject trace the acceleration of the decline of the patient–physician relationship to the ascent of the curve of specialization after World War I. Simultaneous increases in group practice are given a share of the blame by some observers. The inevitable outcome of these movements in the interest of improved professional service has been a decrease in general practitioners.

Before ascribing a causal relationship of this modern trend to the deterioration of professional relationships and the consequent sacrifice of public support, let us carry the inquiry a bit deeper. Medicine is clearly on the defensive. We have openly been charged with reducing the output of our medical schools in the interest of a monopoly of services. The decision of a high court of the land has found medicine to be a trade. Hospitalization insurance was belatedly accepted by organized medicine as a sound economic policy after a delaying action of several years. Voluntary health insurance followed on its heels. Discriminatory action in the registration of physicians up to 50 years old is enforced by Selective Service. The draft beyond the legal age limit applies only to medicine. Federalization of medicine has become a national issue.

Perhaps we would do well to look to some of the sources of individual disaffection and frank opposition to medicine. A lack of geographic coverage is perhaps a more cogent basis of serious criticism of the medical situation in this country than the numerical inadequacy of physicians. Admitting the wider sphere of activity of the modern physician by reason of improved facilities, roads, and transportation, there remain certain areas, usually marginal in economic, social, and educational outlets, in all states without adequate medical coverage. The local community and the responsible representatives of medicine have not realistically resolved their mutual problem (and responsibility) about a common board. Indeed, as in many other areas of public welfare, the physician has too frequently been the led rather than the leader.

An ominous answer to the withdrawal of regular practitioners of medicine from the rural areas is appearing widely over the country. Through the years my duties have taken me into a prosperous agricultural district of Wisconsin. From time to time an older physician has retired or died in one of the small towns along this highway. In each instance his place has been taken by an irregular practitioner; *i.e.*, osteopath or chiropractor. In one of our neighboring states over half the country practice is in the hands of osteopaths. Heed well the signs at the crossroads. The affection of the people lies close to the hearthstones of their homes.

In urban communities, in the interest of preserving a semblance of hygienic life, physicians have placed a limit upon their office hours and have attempted to free an afternoon or a day for rest or recreation. Such a protective device is universally applied in all trades and professions; yet a hue and cry goes up when the physician seeks surcease from his daily tasks. What would occur were a 40-hour week decreed for or by medicine? Seriously, until very recently no assurance of medical coverage was given. With characteristic rugged individualism, each physician went his way—and the devil (or the chiropractor and osteopath) took the patient!

With the stupendous growth of medical knowledge, a premium has been placed upon technical details. In the approach of the physician, the etiology of disease apparently replaced the personal interest in the human host of the disorder. At the same time the public was afforded a certain measure of information on medical matters through the press and radio that prepared him for closer rather than more removed professional confidences. Naturally he resented being treated as a human test tube or the innocent vehicle of interesting scientific findings. The physician in honest absorption in the clinical problem overlooked that essential to sound medical practice; namely, an understanding heart. Unfortunately, finances raised their ugly head to mar the idealistic tradition of medical disregard for material reward. While altruism in medicine has always been a cherished and natural inclination, the exploitation of the physician's weakness in monetary matters has not redounded to the credit of the profession. The reaction of recent years has been even more distressing. Two chil-

dren, 8 and 9 respectively, were riding in the rear seat of an automobile through a small Wisconsin town, when one said flatly, "That's the doctor's house." "How do you know that?" queried the other. "Why, it's the biggest one in town," she answered. Try the test in your own community and then ask why medicine has become the singular target of criticism. Not only is this factor a dominant argument, but it has become a boomerang in our efforts to obtain adequate support for medical education.

To this important question must be attached the very devastating practices of fee splitting and "ghost" surgery, since they have their roots in the mire of unethical financial arrangements between physicians who have wandered far from the basic precept of our profession, "Medicine exists for the benefit of the afflicted and not the afflicted for the benefit of medicine." To traffic in human suffering is as immoral as it is unethical. To these financial excesses and irregularities medicine owes much of its current difficulties. However, let it be clearly understood—the whole profession suffers from the sins of a few who should be unmercifully exposed in their infamous pursuits.

Although many patients have a fragmentary knowledge of their medical conditions, they are almost devoid of knowledge of the devices that medicine has through the centuries developed for their protection. Psychologically, complete frankness on the part of the physician may render him a serious liability to the sensitive patient. Rarely is absolute candor helpful to the desperately ill patient. Contrary to the recently expressed thesis, few patients can really take it when the cards are down. We must "temper the wind to the shorn lamb." I hasten to add that a responsible member of the family must always be apprised of the true situation. "He is the best physician who is the best inspirer of hope." Careful explanations of the probable course of events will often prepare the patient and the family for unanticipated reverses or delays in convalescence. Appropriate consultations are a measure of strength, not weakness. Moreover, pains in explaining the place of records and x-ray films may spare both contracting parties discomfiture at a later date. Legally, such records are not owned by the patient; the physician is the trustee or custodian of a constructive trust in which the patient is the real beneficiary, but the latter has no proprietary rights.

Having in some measure outlined the problem, let us turn to the prognosis. Frankly, without a reconciliation of the differences, individual and collective, between the public and the medical profession, the prospect of reclaiming lost ground is remote. Serious consideration must be given to the primary advantage of the reestablishment of such rapport; namely, an assured improvement of medical care. Selfish and ulterior motives are unworthy and predicate the ultimate defeat of our aims. Medical economics translated into terms of personal advantage has carried our profession far from its objective. With prompt and adequate treatment, medicine may reclaim its lost ground and rise to new heights in the public esteem.

If you have accepted these tenets, American medicine in its most vaunted position of scientific advancement is socially ill. Its neighbors at the common board look askance at our manners and behavior. Before a patient can be treated effectively, he must admit that he is not well. The first step in treatment thereafter is a rededication of medicine to the service of humanity. Short of this fervid declaration of faith, no disciple of medicine is worthy of his calling. Since general practice constitutes over 80 per cent of medical service, it must be given the dignity in the medical family that it merits. These worthy practitioners have manned the ramparts and outposts of medicine from the beginning of historical time. The fawning attention paid to their essential functions by "Johnnies-come-lately" in frock coats and dinner jackets on appropriate occasions must be revolting to the thoughtful physicians in general practice, who until recently were supposed to find full sustenance in the crumbs from the tables of the mighty. If these newly found friends in the profession be really serious, may I suggest that they find sections in their state medical societies and staff positions in their hospitals for these worthy fellow physicians. As family counselors, they will grow in numbers and usefulness with just a modicum of sympathetic support from the profession at large. Since specialization has been responsible in a considerable measure for the shrinkage of medical coverage in smaller communities, the expedient of requiring an apprenticeship

of one to two years of general practice before admittance to a residency or fellowship might well fill this hiatus. From such an exposure would come the natural by-product of improved patient–physician relationship among specialists. To those who elect general practice as a career, facilities should be made available to practice medicine on a modern plane. A health center or a cottage hospital with a minimal auxiliary staff would enable a young physician to maintain standards of medical service commensurate with his training. Associate practice, involving the pooling of resources, material and professional, of two or more young men has operated satisfactorily in certain removed areas of Wisconsin.

The necessity for 24-hour coverage would seem too obvious to require comment. Yet the failure to afford medical service upon enforced absence has constituted a major breach with the public. Tradition has given to the young members of the profession the prerogative of night calls. In many communities this formula is no longer considered a natural entree to practice. Indeed, in some of our Wisconsin towns the older practitioners are more responsive than their juniors to these importunities. Regardless of the unreasonable nature of many of these interruptions of one's rest, we must remember that the layman is not equipped to give sound judgment in such situations, else there would be no need for physicians. In some towns of my acquaintance, osteopaths and chiropractors advertise that *they* answer night calls. A word to the wise!

The medical profession must take a positive stand on the financial activities of its fellows. The Principles of Ethics of the American Medical Association read, "The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration." The fees of family counselors have not risen proportionately to the general economic scale or the cost of living. On the other hand, fabulous incomes have been derived in certain of the specialties without justification upon grounds other than the ability of the patient to pay. The sliding scale has been defended upon the specious contention that the rich pay for the poor. These modern Robin Hoods have made state medicine seem a natural solution to many superficial students of the subject. As one writer states, the defense that the wealthy man's life is worth so much more constitutes "biologic blackmail." Fee splitting is openly condemned and secretly condoned in certain quarters. If medicine does not clean house, a Kefauver will do it for us. As slimy as is this practice, "ghost surgery" offers even greater potential danger to the patient, who neither sees nor knows the surgeon who sells his mechanical skill and moral integrity for a price. Medicine cannot survive these subversive practices. Incubuses on our moral fibers, either they are sloughed off or we perish.

Fortunately, medicine has come to realize that the public has a place in the consideration of its own welfare. In 1947, Colorado instituted the grievance committee to which patients and the public in general were invited to bring their complaints. Notices to this effect were placed in physicians' offices and in the public press. At first the "crackpots" and psychoneurotics dominated the scene. Then sound criticisms were received and promptly considered at the community (county) level. Financial misunderstandings were not common. The plan has spread over the country, and the results have justified the effort. Not the least of the favorable effects of its operation has been an improvement in professional relations. Medicine has opened its doors to the direct criticism of its constituent members.

George Bernard Shaw exclaimed, "Independence? That's middle-class blasphemy. We are all dependent on one another, every soul of us on earth." Medicine has maintained a position aloof from the body politic. We have been conservative to the point of isolationism in our reactions to social responsibility. "The time is already here where to be only a practicing physician is a discredit. Not only has the medical profession to furnish its full quota to the army of social service but in many respects it must point out the way. The pathology of society is as much the function of the medical man as the pathology of human disease." This pronouncement did not come from Soviet Russia or socialistic Britain yesterday, but from Chicago in 1909. Henry Baird Favill, a distinguished physician with a large and wealthy clientele, was addressing the alumni of Rush Medical College. His challenge has passed unheeded in the main because medicine and medical men are still more interested in curative than preventive measures. Posterity will acclaim the prophet Favill

years hence. But our objective is none the less clear. Before a truly effective job in preventive medicine can be done, medicine must align itself with the social forces now assembling to limit or eliminate the hereditary, nutritional, environmental, and occupational factors in the production of disease and disability.

Medicine has been backward in fostering so-called public relations. In recent years, press-radio conferences have been encouraged at state and county levels. Many of the fancied differences may be resolved about a round table, when the common objective of the public weal is met by the participating representatives. Furthermore, such gatherings afford the opportunity for the education of an important source of lay information on medical matters. In such details as privileged information from a medical standpoint, there is a woeful lack of understanding by the fifth estate. Time was when the physician was the center of civic activities. This position obtains only in smaller communities today and, significantly, in the person of the general practitioner. Physicians would render the profession, as well as the public, a superior service by active participation in voluntary health forums and other civic projects in the interest of the advancement of community health and happiness.

To reclaim the enviable patient–physician relationship of the past, we must maintain an interest in the patient as a human being. Let him never feel that his misfortune is your intellectual or financial gain. Share that portion of your knowledge of his condition as he should understand in the interest of cooperative therapeutics. The psychological lift may be a determining factor in the battle—and he *is* the party of the first part. In this day the design of detailed laboratory tests may be imparted; but it must never imply abysmal doubt to be resolved only by random probing. Prognosis is a most unfaithful ally. Yet cautiously used with a background of wide experience, an accurate forecast of a clinical disorder brings great dividends of confidence and cooperation. As previously indicated, in all serious conditions some dependable member of the family must share the burden of knowledge of the gravity of an illness. It is axiomatic that the survival of a loved one for whom an unfavorable prognosis has been given is a happy circumstance; but rarely is a fatal termination overlooked when a favorable prospect has been vouchsafed. The thoughtful physician will maintain contact after the discharge of a patient, especially if the illness has been serious or protracted. In larger institutions and communities, social service will maintain this continuity; but I submit that this important agency must be an instrument, not the end to our design. Preferably, by personal telephone call or note, the physician may manifest his interest in the patient's progress—without fee! In no other manner may patient-physician relationship be more solidly cemented.

Maimonides (1135–1204), the great Jewish physician, left one of the gems of medical literature in his prayer. Engraved on the heart of every physician should be his words: "Let me see in the sufferer the man alone . . . Let me be intent upon one thing, O Father of Mercy, to be always merciful to Thy suffering children." Rededicated to service to humanity and stripped of mysticism and pomposity, medicine will take its proper place in the social fabric. In mutual confidence and respect, medicine will be restored to its lost estate as the most humane and effective agent for the advancement of mankind.

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* Veterans Administration.

PHYSICIANS REMINDED OF NARCOTICS REGULATION

By July 1, all physicians registered under the Harrison Narcotic Act or under the Marihuana Tax Act must have effected re-registration. Very severe penalties may be invoked in case of failure.

If you have not received forms for separate registration and inventory of narcotics and marihuana, write immediately to the office of the Director of Internal Revenue, Federal Building, Milwaukee 1. It is the responsibility of the physician to effect re-registration, make out inventories, and pay the annual tax or taxes. Physicians having two offices *must* register for both, as each office must have a separate registration number. Physicians in service are exempt.

Uses and Abuses of Oxytocics in Obstetrics*

By HOWARD J. TATUM, Ph. D., M. D.**
New Orleans, La.

OXYTOCICS are drugs whose primary pharmacologic action is to produce a stimulation of the uterine musculature such that the uterus contracts. The term oxytocic includes two basic drug groups. The first consists of ergot and various synthetic derivatives, while the second group includes those biologic preparations and synthetic analogues derived from the posterior pituitary gland.

Ergot preparations have been used extensively in obstetrics since John Stearns[1] in 1808 popularized their use and named ergot the "*pulvis parturiens*." Ergot was used so indiscriminately that it became known in 1824 as the "*pulvis ad mortem*." This abuse in many instances resulted from the use of ergot for the production of abortions. Since ergot has relatively little effect upon an early intact pregnancy, many failures resulted; and dosages were increased by such magnitude that the toxic manifestations of ergot became of clinical importance. These excessive doses resulted in peripheral vasoconstriction with subsequent development of gangrene of the extremities. More recently, Ergotrate or ergot preparations have been employed widely in the conduct of the third stage of labor.

The second drug group consists of preparations from the posterior pituitary gland. The original extracts of the posterior pituitary contained a mixture of vasopressor-antidiuretic fraction and a true oxytocic fraction. Kamm and associates[2] separated and concentrated certain fractions of posterior pituitary extract. Subsequently it has been possible to prepare a highly purified oxytocic fraction which has but slight vasopressor and antidiuretic action. More recently, du Vigneaud and associates[3] have synthesized an octapeptide amide which shows promise of being identical to the naturally occurring oxytocin.

The pharmacodynamics of the uterus have been described in the following manner by Salter.[4] The uterus is to some extent under the control of both branches of the autonomic nervous system. Cholinergic impulses are conducted along the pelvic nerves. Adrenergic impulses come from the inferior hypogastric ganglia along postganglionic fibers. Stimulation of either system increases the motor activity of the human uterus. Denervation, on the other hand, produces little change in uterine tone or in spontaneous contraction. Reynolds[5] demonstrated that, after castration, both tone and activity of the uterus declined. In all probability, endocrines are more important with regard to uterine activity than are nervous impulses. There have been many instances reported where complete traumatic section of the spinal cord has been followed by normal labor and delivery.

With regard to the toxicity of these two major groups of oxytocics, it may be said very briefly that any drug when misused can and frequently will produce untoward toxic manifestations. The classic statement made by one of my former professors at the University of Wisconsin Medical School is: "The dosage of any drug is *enough* (to produce the desired results)."

The general philosophy concerning the use of oxytocics in obstetrics can be stated succinctly in the following manner. The only justifiable rationale for their use in obstetrics is for the initiation or enhancement of uterine activity in a manner which as closely as possible simulates a *normal uterine mechanism*. Most of the serious complications have resulted from a failure by the physician to adhere to this simple philosophy. When these drugs are used in such dosage that the uterus reacts in a manner beyond the normal capacity of that organ, serious consequences are prone to occur.

Specific Indications

The philosophies which dictate the use of oxytocics vary somewhat with the phases of pregnancy. For this reason, the indications for their employment during the *prenatal,*

* Presented at the One Hundred and Thirteenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 6, 1954.

** From the Department of Obstetrics and Gynecology of the Louisiana State University School of Medicine and Charity Hospital of Louisiana, New Orleans.

the *intrapartum*, and the *postpartum* periods will be described separately.

PRENATAL PERIOD

The oxytocics may be used to "prime" the cervix and fundus. The term "priming" of the uterus may be otherwise described as a forced ripening or maturing process such that the onset of labor will be earlier than could be expected if nature were allowed her own course. "Priming" of the uterus should be used only when there is no necessity for immediate delivery such as would exist in face of severe hemorrhage. The oxytocics are administered to produce rhythmical uterine contractions for a limited period of time. The usual course of events is that oxytocics are given for a three-, four-, or five-hour period and then discontinued for 24 to 36 hours. Quite frequently one, two, or occasionally three such periods of stimulation are necessary before "spontaneous" labor begins and proceeds in a normal manner. Patients with chronic hypertension who fail to respond satisfactorily to the usual therapeutic measures and who are near term logically would be candidates for this "priming" procedure.

It is difficult at times to separate the "priming procedure" from true *induction of labor*. For the induction of labor, a specific indication for the prompt termination of pregnancy must be present. The oxytocics are used with a specific demand that true labor, or at least the termination of pregnancy, promptly follow their use. There are many specific indications for medical induction of labor, but only a few will be mentioned in this discussion. Induction of labor or early termination of pregnancy in the patient with *diabetes* is a controversial subject. Many babies of these patients are lost within the last two or three weeks of pregnancy; and in order to circumvent this catastrophe, induction of labor prior to this critical period is advocated by many. Not infrequently, diabetic mothers produce excessively large babies with resulting simple pelvic and shoulder dystocia. This fact in itself may justify early induction of labor before disproportion develops. One must never forget, however, that babies of diabetic mothers may be physiologically immature even though they are of excessive or full-term size. For this reason, the hazards involved in disproportion and delivery of a functionally premature baby must be weighed carefully with regard to the ultimate results. A long difficult labor is contraindicated in the diabetic patient; and hence, extreme care should be exercised in deciding which of these patients can be expected to respond satisfactorily to oxytocic induction.

The patient with *true toxemia* may present indications for the induction of labor. Although a tremendous amount of information has been accumulated concerning toxemia of pregnancy, there is as yet no specific treatment for this serious complication other than the termination of pregnancy. Hence, when it has become apparent that medical therapy has failed, one must proceed to the ultimate goal; namely, that of emptying the uterus. It should be strongly emphasized at this point that induction of labor should not be considered as a specific treatment for pre-eclampsia or eclampsia, but should only follow the failure of medical management. Under these circumstances, every effort must be made to effect delivery by the least traumatic method. In certain instances this may mean the induction of labor; in others, it may mean the termination of pregnancy by cesarean section.

A third specific indication for the induction of labor is the *potential* or *actual presence of intra-uterine infection*. When amnionitis is present, continuation of pregnancy will jeopardize the life of the mother as well as that of the fetus. In such patients, the uterus should be emptied without undue delay. In most instances, vaginal delivery is preferred since abdominal delivery is usually associated with greater morbidity. The presence of intra-uterine infection, then, is a definite indication for induction of labor by means of the oxytocics. In individuals who have experienced premature rupture of the amniotic membranes but who present no clinical evidence of intra-uterine infection, the danger of imminent amnionitis increases with the passage of time and cannot be overlooked. Repeated vaginal or rectal examinations, as well as uterine contractions, greatly increase the potentiality for amnionitis to develop. If the individual with premature rupture of the membranes is far from term, conservative management is certainly justified in the *absence* of intra-uterine infection. On the other hand, if the individual is at or near term, the dangers of conservative management are probably greater than the dangers associated with careful induction of labor by means of the oxytocics.

Acute nephritis is perhaps one of the best examples of one of the less common medical conditions which is worsened by the continuation of pregnancy. Acute nephritis developing during pregnancy is extremely hazardous for the mother, and the consensus generally is that the pregnancy should be terminated. In a patient in whom this severe complication has appeared during pregnancy and for whom the decision has been made to terminate pregnancy, the method chosen should be the one which is the least traumatic to the mother. The induction of labor with oxytocics in this situation is worth serious consideration. Time does not permit further enumeration of the various medical conditions which may indicate immediate induction of labor.

Intra-uterine bleeding is a sign which suggests one of two primary diagnoses: first, *placenta previa,* and second, *premature separation of the normally implanted placenta.* The diagnosis of placenta previa can usually be made by one of two methods: first, by palpation of the placenta through the partially dilated cervical canal; and second, by contrast roentgenologic studies. When the diagnosis of placenta previa has been made, the problem of method of delivery arises. In general, if the placenta is located such that delivery of the vertex can be accomplished without serious jeopardy to the mother or to the baby, then vaginal delivery would seem to be the procedure of choice. In such cases we have found that artificial rupture of the membranes, followed by induction of labor by intravenous administration of dilute solutions of Pitocin, effectively controls bleeding in the majority of instances and permits delivery of a live baby from a live mother. The uterine contractions initiated by amniotomy as well as by the oxytocic, produce an effective tamponade and, hence, tend to prevent excessive bleeding. Should excessive bleeding develop, or should there be evidence of fetal or maternal distress, then delivery should be effected by cesarean section.

Premature separation of the normally implanted placenta is the second most common cause of intra-uterine bleeding prior to the onset of labor. This diagnosis is usually made by excluding the presence of placenta previa. In addition, there are other signs and symptoms which should lead one to make the presumptive diagnosis of placental abruption. In a previous publication[6] our general philosophy with regard to the management of placental abruption has been presented. In general, this philosophy calls for the initiation or enhancement of the uterine mechanism such that vaginal delivery can be accomplished. In pursuing this philosophy, amniotomy is performed and is followed by the intravenous administration of dilute solutions of Pitocin. At the present time, we are not sufficiently dissatisfied with this philosophy to change from the medical to the surgical management of abruptio placentae. There obviously are specific exceptions to this philosophy, and these have been enumerated elsewhere.[6] Extensive experience with the careful use of oxytocics in the treatment of placental abruption has led to the conclusion that very gratifying results can be obtained by this procedure. Our results do not add support to the conclusions of Page[7] that the oxytocics are contraindicated in the treatment of placental abruption.

Oxytocics may be used during the prenatal period as *diagnostic aids.* The diagnosis of an abdominal pregnancy in the absence of obvious intraperitoneal bleeding may be materially aided by the judicious use of dilute intravenous Pitocin. Pitocin will usually effect a uterine contraction, permitting accurate localization of the fetus. This "Pitocin Test" has been described by Colvin and McCord[8] and by Cross, Lester, and McCain.[9]

A final general indication for the prenatal use of oxytocics is for the termination of an *incomplete abortion.* The consensus has been that a medical completion of the abortion is desired when there is an associated intra-uterine infection. Surgical completion of a septic abortion is apt to be accompanied by frequent serious complications.

INTRAPARTUM PERIOD

There are three major indications for the use of oxytocics during the intrapartum period which should be mentioned at this time. The first and most important of these is *uterine inertia.* A true primary uterine inertia is associated with marked jeopardy to the fetus as well as not infrequent morbidity of the mother. The best treatment of primary uterine inertia is time. However, a limit must be placed upon the period of time which may be endured by a mother and a fetus without increasing fetal or maternal morbidity. When that time has lapsed, one must choose between abdominal delivery and enhancement of the uterine mechanism by

means of oxytocics. At this point, I would like to quote Dr. Nickolson J. Eastman,[10] who states that: "uterine inertia also takes its tolls in terms of intrapartum infection, exhaustion, difficult forceps, Dührssen's incisions, and so forth. Which is the lesser evil: pituitary extract or stubborn uterine inertia? Having been brought up to believe that the administration of pituitary extract before the birth of the baby constitutes the most heinous of obstetric sins, but during the past five years having observed its ultra cautious use in several hundred cases of uterine inertia, I am inclined to believe that the balance lies slightly in favor of pituitary extract provided, and provided again, that certain rigid rules be observed." The conditions which must be met in this situation are: first, true primary uterine inertia must be present; second, there must be absolutely no question as to the adequacy of the passage for the passenger as determined by evaluation and re-evaluation of pelvic measurements and estimation of fetal size; and third, a normal presentation must be present. Oxytocics may then be utilized for the purpose of augmenting a poor uterine mechanism to the point of and only to the extent of producing a *normal* uterine mechanism. It is the author's firm conviction that this goal may be safely reached only by "titrating," if you will, the uterine contractions by means of dilute oxytocic preparations administered intravenously. This means of administration permits accurate control upon the effect of the oxytocic, and one may eliminate the majority of serious accidents which have so frequently blackened the record of oxytocics when used prior to delivery of the child. It is impossible to predict at what time, if ever, a normal uterine mechanism will be reestablished. By superimposing such a normal mechanism upon the oxytocic-produced contractions, a *supernormal* mechanism may result. This type of supernormal mechanism has produced innumerable uterine ruptures. The fact that the combination of the normal uterine mechanism and the effect of oxytocics can never be safely predicted makes mandatory that there be extremely close and constant observation of the patient by a physician who is cognizant of the inherent dangers of the method. Under no circumstances should this duty be delegated to a nurse or to any person other than a competent physician.

Secondary uterine inertia differs little from primary uterine inertia with regard to its treatment except that even more care, if possible, must be taken to exclude mechanical obstruction in the birth canal. Also, rest is extremely important in this situation and frequently will in itself permit reinstitution of a normal uterine mechanism. However, if rest fails and if the other conditions are present whereby one may use oxytocics with a reasonable degree of safety, then they should be used as in the primary uterine inertias.

A third indication for the use of oxytocics during the intrapartum period is thought by some authorities to be the administration of one or another of these drugs at the time of delivery of the posterior shoulder. Dieckmann and associates,[11] who have advocated the use of oxytocics at this phase of delivery, stress the fact that, with their use, less bleeding occurs during the third stage of labor, since the oxytocics enhance placental separation and expulsion. There are, however, certain hazards involved in the use of oxytocics at this time. Placental retention is the most common complication which may occur. When a placenta is retained because of the use of oxytocics during the terminal phase of the second stage of labor, and it certainly does occur, then one must resort to the manual removal of the placenta, which in itself increases maternal morbidity. I cannot answer the question as to whether or not the decreased amount of bleeding usually met with during the third stage of labor compensates for the occasional instance in which a placenta is retained, necessitating an operative procedure.

POSTPARTUM PERIOD

The use of oxytocics for the augmentation of hemostasis in the immediate postpartum period has become common practice to every obstetrician. Undoubtedly, this routine significantly decreases blood loss during a critical period. Inasmuch as the uterus is empty at this time and cannot rupture, the route of administration is of little importance unless immediate effects are imperative.

The use of oxytocics following the emptying of the uterus by cesarean section greatly reduces blood loss during the process of surgical repair. However the rationale for the injection of these drugs directly into the uterine musculature, as is commonly practiced, is difficult to comprehend. These drugs produce their effect by direct action upon the

muscle cells and hence must come in contact with the majority of myometrial cells before the uterus will contract as an organ. Certainly, more muscle cells will be affected if the drug is administered intravenously than if it is injected directly into the uterine wall.

The oxytocics have proved to be of inestimable value for the prevention of *postpartum hemorrhage.* This serious complication can be anticipated in certain types of patients, and the necessary precautions can be taken. One to three ampules of Pitocin or Ergotrate may be added to one liter of glucose solution. This solution is then administered intravenously for a period of one to three hours, beginning as soon as the placenta has been delivered. Adherence to this precautionary measure for the past four years has effected a dramatic reduction in the incidence of postpartum hemorrhage occurring on the Louisiana State University Obstetric Service at Charity Hospital in New Orleans. It should be emphasized that this routine is utilized only in the types of patients in whom postpartum hemorrhage is likely to develop. These types of patients include grand multipara, those with multiple pregnancy, polyhydramnios, prolonged labor, etc.

Contraindications for the Use of Oxytocics in Obstetrics

In the present era of preventive medicine, it is incongruous that certain practices in obstetrics are being utilized with utter abandon. The most widely abused procedure in obstetrics is the use of oxytocics for the induction of labor solely for the convenience of the physician or the patient. A very crude but fair analogy would be to consider the presence of a uterus as an indication for a hysterectomy.

Innumerable treatises have been written stressing the necessity for excluding any possibility of disproportion before oxytocics are considered in the treatment of prolonged labor. Unfortunately, even in this enlightened age, women are dying because this obvious precaution is being neglected.

An abnormal condition of the myometrium such as that associated with uterine scars resulting from previous cesarean sections or myomectomies generally contraindicates the use of oxytocics. In these abnormal uteri, the obstetrician cannot know with any degree of certainty the intensity of contraction which can safely be withstood by the uterus.

Potential Hazards in the Use of Oxytocics

When these drugs are administered prior to delivery, the uterus occasionally responds hyperactively with the result that a tetanic contraction is produced. The resultant effect upon the fetus may be irreversible. In addition, the placenta occasionally becomes separated as a result of this tetanic contraction. Amniotic emboli and maternal death have occasionally followed severe uterine contractions produced by oxytocics.

The combination of cyclopropane anesthesia and certain oxytocics has been shown by Morris, Thornton, and Harris[12] to result in frequent cardiac irregularities. Also, the entity known as "Pituitrin Shock" should always be considered. This condition has been described by Adelman and Lennon,[13] Kanter and Klawans,[14] Krettek and Russum,[15] and others. The consensus is that the shock is due either to an anaphylactic reaction to foreign protein or more probably to pressor action upon the coronary vessels with resulting myocardial ischemia. This shocklike state can be readily treated by epinephrine, ephedrine, plasma, or whole blood. The oxytocics also occasionally produce hypertension, headaches, and gastrointestinal symptoms as described by Carvalho and associates.[16] For this reason, they should be used with caution in the patient with pre-existing hypertension.

The most serious potential hazard in the use of oxytocics is uterine rupture. This complication must be considered to be almost always preventable. In most instances the uterine rupture may be attributed to one of two major factors. The first is that fetopelvic disproportion has not been ruled out prior to the institution of oxytocic therapy. The second factor is that the uterus has been whipped to supernormal efforts by excessive quantities of oxytocics. In the author's opinion this control of dosage can only be safely and accurately managed when the oxytocics are given intravenously in very dilute solutions. Only by this method of administration can the proper dosage be ascertained with a reasonable degree of safety. To illustrate this point further, I should like to pass on to you some mortality figures which recently came to my attention. During a recent twelve-month survey[17] in a Midwestern state, there were 39 maternal deaths attributed to obstetric causes. Fifteen of these patients had ruptured uteri. Of these fifteen, six had received

Pitocin during labor; and in each of these six patients, the drug had been administered intramuscularly. Two of these patients had obstructive labors where oxytocics should never have been used. Judging from the results, it would appear that the remaining four patients had received excessive amounts of Pitocin.

Summary

The indications for the use of oxytocics in obstetrics are numerous and have in no way been completely covered in this discussion. An attempt has been made, however, to present a basic and practical outline of their uses.

It is the opinion of the author based upon his experience that oxytocics may, upon proper indications, be used in obstetrics whenever normal labor would ordinarily be permitted. In other words, the presence of multiple pregnancy, polyhydramnios, breech presentation, or grand multiparity do not necessarily contraindicate the use of oxytocics for the treatment of uterine inertia, etc.

In addition, some of the more common and serious complications resulting from their administration have been reviewed. Therapeutic individualization must be religiously practiced whenever one of these drugs is given. This individualization should encompass consideration of the type of drug to be used, the route of administration, and the dosage required.

Oxytocics are extremely valuable when used skillfully and with discretion. If they are used indiscriminately and improperly, they may be the cause of tragedy.

Louisiana State University School of Medicine.

I wish to express my gratitude to Dr. James G. Mule, research associate, Department of Obstetrics and Gynecology, and to Miss Ann Hodge, assistant librarian at Louisiana State Medical School, for their valuable assistance in the preparation of this paper.

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Two Recent Medical and Surgical Advances in the Control of Aqueous Production in Glaucoma*

By JOHN A. BUESSELER, M. D.
Madison

DURING the past decade major advances have been made in the understanding of glaucoma. Investigators[1] have announced many discoveries about aqueous formation and dynamics, about the pathology and diagnosis of ocular hypertension, and about the medical and surgical treatment of elevated intraocular pressure. While a particularly great amount of research effort has been directed toward explaining the production and circulation of aqueous humor,[2,3] the medical[4–6] and surgical[7–9] control of aqueous production has progressed at an almost equally rapid rate.

Medical Control

The most recently reported[10–12] drug for reduction of aqueous formation is acetazoleamide, Diamox.** First developed by Roblin *et al.* [13] and Miller *et al.*[14] as a diuretic agent because it inhibits carbonic anhydrase in the renal tubular epithelium, this heterocyclic sulfonamide is capable of producing a marked, rapid, and moderately sustained reduction in intraocular tension. Although Friedenwald's hypothesis of aqueous secretion,[2,3,15,16] based on electron transfer through the ciliary body stroma-epithelium barrier, does not identify carbonic anhydrase as the enzyme that facilitates aqueous production, the clinical studies with acetazoleamide suggest that the site of inhibition is in the ciliary body secretory mechanism itself rather than in the general diuretic effect.

In a preliminary clinical report on the ophthalmologic use of Diamox, Becker[10] told of administering the drug to 19 patients in the form of a single oral dose of 500 to 1,000 mg. He stated that no side reactions were observed following the single doses but that 2 patients complained of paresthesia of the fingers and toes after repeated administration of the drug. In his group, 25 eyes of 15 patients possessed various types of glaucoma uncontrolled by conventional methods; and all of these showed a pronounced decrease in intraocular pressure following oral Diamox medication. In this series, reduction in ocular tension started within 60 to 90 minutes and reached its minimum level in 3 to 5 hours. Tonographic tracings revealed that the fall in pressure was effected without apparent change in the aqueous outflow mechanism. Ten normal eyes in the series responded similarly but with much smaller decreases in pressure.

Posner[11] administered the drug in 250 mg. oral doses two to four times daily and reported dramatic reduction in ocular tension, as well as deepening of the anterior chamber. He observed opening of the angle in several cases of narrow angle glaucoma which previously failed to respond to the strongest miotics.

A recent paper by Breinin and Görtz[12] outlined their experience with acetazoleamide and their theory about the mechanism of its reduction of aqueous formation. They postulated that carbonic anhydrase acts as a catalytic enzyme in aqueous secretion, and they presented evidence that it exists in the ciliary body in quantities comparable to that in the kidney. A similar suggestion, based on animal experimentation, has been made by Green, *et al.*[17] The conjecture of Breinin and Görtz that a reduction in aqueous electrolytes, and therefore a reduction in aqueous osmotic pressure, results from the administration of the drug was strongly supported by their clinical findings of normalization of water provocative test curves in patients with chronic simple glaucoma who were receiving acetazoleamide therapy. Their criteria for clinical success or failure in the treatment of glaucoma by this medication were sharply defined and demanded that, in order for the method to be considered a success, the ocular tension must have been normalized and so maintained throughout the entire period of observation, which in some cases amounted to several months. Of their group

* Presented at the November 1954 meeting of the Madison Eye, Ear, Nose and Throat Society.

** (R) Lederle Laboratories Division, American Cyanamid Company.

of 32 cases studied at length, 17 were regarded as therapeutic successes and 15 as failures. They found that, of all cases, ocular hypertension secondary to uveitis offered the highest rate of success in treatment with acetazoleamide and that chronic simple glaucoma showed the least satisfactory rate of success. In this regard, it was apparent that the rate of success was almost inversely proportional to the duration of treatment. On prolonged acetazoleamide therapy, many of their patients became refractory and frequently experienced a gradual return to elevated ocular tension. In the words of Breinin and Görtz, "acetazoleamide acts as a sort of medical cyclodiathermy." In regard to its toxicity, they reported that all of the patients who received 500 mg. or more a day had paresthesia in their hands and feet; a few cases also complained of nausea, anorexia, drowsiness, and polyuria. No ocular toxicity was observed. Acidosis and hepatic cirrhosis were considered to be contraindications to acetazoleamide therapy.

The current ophthalmologic indications for using Diamox are:

1. To lower elevated ocular tension prior to intraocular surgery
2. To prevent ocular hypertension following cyclodiathermy
3. To provide a safety factor before dilating the pupil for ophthalmoscopy in cases of narrow angle glaucoma
4. To temporize in patients who are poor surgical risks
5. To restore an anterior chamber which has collapsed or failed to reform during postoperative convalescence following cataract extraction, particularly in the presence of choroidal detachment, or following intraocular glaucoma surgery
6. To control secondary ocular hypertension in cases with acute uveitis or traumatic hyphema.

Surgical Control

Since Vogt in 1936 conceived the technic for reducing intraocular pressure by subjecting the ciliary body to a barrage of 50 to 100 perforating electrodiathermy puncture wounds through the overlying sclera,[18] considerable interest and ingenuity have been expended in improvements in this surgical treatment of glaucoma known as cyclodiathermy. One type of modification has been that of the nonperforating procedures of Weekers,[18] Castroviejo,[19] and Bietti.[20] Another change in surgical technic is that of intentionally interrupting the ciliary arteries according to the perforating coagulation procedures of Schreck,[21] Acto–Peis,[8] and Arruga.[8]

Still, no general agreement has existed concerning the value of cyclodiathermy; and in the experience of many who have used it, its effect is only temporary.[7] In addition, several cases of sympathetic ophthalmia have been reported not only following perforating technics but also after nonperforating cyclodiathermy; therefore, in the opinion of Haas,[9] the procedure should be contraindicated for a blind eye in the presence of a functioning fellow eye.

Recently, however, Becker[22] described a relatively successful surgical method of reducing aqueous production. It combines the better principles of both the previously mentioned modifications of cyclodiathermy surgery. His technic utilizes nonperforating diathermy and interruption of the ciliary arteries. It consists simply of electrocoagulating the medial and lateral long posterior ciliary arteries, under direct visualization, at their points of entry into the sclera on the posterior aspect of the globe; in addition, five of the seven branches of the anterior ciliary arteries are interrupted by electrocoagulation under direct visualization prior to their entry into the sclera in the tendinous portion of the recti muscles. Thus, an ischemia of the ciliary body is produced without having to traumatize it by either the perforating or nonperforating methods previously used.

Case Report

The following case illustrates how both of the recent medical and surgical methods for controlling aqueous production in glaucoma were utilized in one patient.

A. B., a bilaterally blind, 24-year-old, white girl, has had diabetes mellitus for the past 13 years. Approximately three months prior to this report, far advanced proliferative retinopathy and nearly complete retinal separation developed in each eye. Her visual acuity at that time was hand movements at ½ meter for the right eye and light perception for the left. Slit-lamp examination revealed the anterior segment of the right eye to be essentially normal; but the left possessed early rubeosis iridis and moderate aqueous flare. Ocular tensions were 8.0 mm. Hg (Schiotz) for the right eye and 30.3 mm. Hg for the left. Gonioscopy revealed the right anterior chamber angle to be wide and open

throughout its extent; the left was markedly narrowed with none of the normal angle "landmarks" visible.

Topical miotic medication was instituted for the left eye; however, the ocular tension continued to rise gradually over a period of 13 days until it reached a high of 71.8 mm. Hg and was associated with severe left eye pain. This medication was then discontinued and Diamox orally was started. Immediately prior to the patient's initial ingestion of 500 mg. of acetazoleamide, the ocular pressure for the left eye was recorded as 55.1 mm. Hg. An hour and a half after the initial dose, it was 40.0 mm. Hg; and it was normalized at 23.4 mm. Hg at the end of three and one-quarter hours. The ocular pressure in the right eye remained unchanged at 14.2 mm. Hg throughout this period.

The patient was continued on oral Diamox medication in the amount of 500 mg. twice daily for the succeeding five days, during which time the ocular tension in the glaucomatous eye remained normalized except for a single elevation to 32.0 mm. Hg. The tonometric readings for the right eye fell to a low of 6.2 mm. Hg. Because of the narrow angle gonioscopy findings, topical miotic medication to the left eye had been restarted on the third day following institution of Diamox therapy.

At this point in the patient's course of treatment, she was seen in consultation at Washington University, St. Louis, Missouri; and because she was beginning to show symptoms and signs of nausea and occasional vomiting, it was suggested that Diamox be continued only until surgical control of the glaucoma could be attempted.

Upon her return, the patient was admitted to the hospital in preparation for cyclodiathermy surgery. Diamox medication was discontinued because of a marked increase in the nausea and vomiting and associated difficulty in maintaining satisfactory control over the systemic diabetes. The two branches of the anterior ciliary arteries in the medial and superior recti muscles and the single branch in the lateral rectus muscle were interrupted in the muscle tendons by electrocoagulation under direct visualization, according to the technic described by Becker.[22] The medial and lateral recti muscles were then severed from the globe at their insertions so that the eye could be rotated sufficiently to permit direct visualization of the medial and lateral long posterior ciliary arteries. These arteries were interrupted by electrocoagulation at their points of entry into the sclera, and the medial and lateral recti muscles were then reattached to the globe at their original insertions.

Three days postoperatively, the ocular tensions were 14.2 mm. Hg for the right eye and 27.1 mm. Hg for the glaucomatous left eye. Slit-lamp examination revealed the left cornea to be clear and the aqueous to possess a mild flare; the anterior segment of the right eye continued to appear normal. In spite of the initially encouraging reduction in ocular tension subsequent to surgery, the left eye showed a gradually progressive rise in intraocular pressure during the following two months until a high of 88.8 mm. Hg was reached; the patient, however, was entirely free of ocular discomfort. Once again, in an effort to effect a lowering of ocular tension in the left eye, Diamox was given orally in the amount of 500 mg. After five hours, the ocular pressure had fallen from the high of 88.8 mm. Hg to 71.8 mm. Hg. During this time, the ocular tension in the right eye fell from 20.1 mm. Hg to 10.0 mm. Hg. An additional 500 mg. of Diamox was given orally; seven and one-half hours later (12½ hours after the initial oral dose of Diamox), it had dropped to 45.3 mm. Hg, for a total overall reduction of 43.5 mm. Hg pressure. The tonometric readings for the right eye reached a low of 6.2 mm. Hg.

Following this test response to Diamox therapy two months after cyclodiathermy surgery, further acetazoleamide medication has been withheld. Since then, the patient's ocular tension has been fluctuating between 55.1 and 75.7 mm. Hg for the glaucomatous left eye, while the right eye has remained normotensive. The patient has been essentially free of ocular discomfort.

Summary

The recent reports on the clinical use of acetazoleamide in glaucoma have outlined the valuable but rather restricted applications for this systemically administered agent in controlling aqueous production. As is almost always the situation in therapeutics, the effectiveness of this medication rests largely on the judiciousness with which the eye physician selects his cases and plans his treatment to conform to the known limitations of the drug.

The surgical control of aqueous production by means of cyclodiathermy has long been a

source of hope and frustration to eye surgeons. Although it is often considered to be a procedure of last resort, the recent modification in technic which avoids directly traumatizing the uveal tract and instead strives for a reduction in aqueous secretion by producing relative ischemia of the ciliary body may eventually enable the procedure to be used in cases where other methods are contraindicated.

110 East Main Street (3).

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First Branchial Cleft Cyst Presenting in the Neck

Case Report

By JOSIAH FULLER, M. D.,* and JOHN C. MURPHY, M. D.**

IN A recent paper, Rankow and Hanford[1] reported 3 patients who had excision of first branchial cleft cysts presenting in the neck. These anomalies consisted of a fistulous tract arising from the anterior aspect of the cartilaginous portion of the external auditory canal, passing anterior to the posterior belly of the digastric muscle, and presenting at the skin below the angle of the jaw. A search of the literature by these authors revealed only 5 additional patients with such an anomaly. Because of the apparent rarity of this condition and because other cases might be mistaken for tuberculous adenitis, as this one was, it is felt desirable to report the case of an additional patient.

A 42-year-old housewife was admitted to the sanatorium with the complaint of recurrent painful swelling and drainage from the left side of her neck for four years. Twenty-eight years before admission she had had a neck dissection for chronic draining sinus on the left side of her neck. After this, she entered a tuberculosis sanatorium and was given a course of x-ray therapy. After four years in the sanatorium, the draining sinus finally healed; and the patient was well for the following 20 years.

Four years before admission she once more began to have recurrent painful swelling and drainage from the left side of her neck. She was given two more courses of x-ray therapy, Dihydrostreptomycin twice a week for a total of 64 Gm., and 12 Gm. of para-aminosalicylic acid daily. In the 28-year period she had had a total of seven operations on her neck. Cultures for tubercle bacilli from the draining sinus were negative on every occasion.

Examination on admission revealed a red, tense, tender swelling in the left side of the neck anterior to the sternocleidomastoid muscle and below the mandible. There was a draining sinus well below the angle of the jaw at the anterior border of the sternocleidomastoid muscle in the middle of an area of diffuse scarring. The left external auditory canal appeared normal.

After a few days of penicillin and hot packs, the inflammatory reaction subsided and the patient was prepared for surgery. Methylene blue was injected into the opening of the sinus, but none of the dye appeared at the external auditory canal. An oblique incision was made along the anterior border of the sternocleidomastoid muscle; and the sinus opening, with as much as possible of the old scars, was excised. Considerable difficulty was encountered in the initial stages of the dissection. This was expected because of the duration of the inflammatory process, the seven previous operations, and the three courses of x-ray therapy. As soon as it was apparent that the sinus tract was extending toward the ear, the incision was extended to the mastoid process in the manner described by Rankow and Hanford. Once outside of the area of inflammation below the angle of the jaw, the course of the sinus was readily dissected bluntly, anterior to the posterior belly of the digastric muscle to the anterior aspect of the cartilaginous portion of the external auditory canal. The facial nerve was not seen at any time during this dissection. The end of the tract was excised with a portion of the cartilage from the external auditory canal. Two Penrose drains were inserted and the wound closed. The wound drained for only a few days, and healing was rapid and complete. There has been no sign of recurrence for 28 months since the operation.

Pathological examinations revealed a sinus tract 8 cm. long and 1.3 cm. in diameter. The wall of the fistulous tract was composed of fibrous connective tissue containing scattered areas of calcification. The lining of the sinus tract was completely replaced by chronic inflammatory tissue. No epithelium

* Thoracic Surgeon, Duluth Clinic, Duluth, Minnesota, and Thoracic Surgical Consultant, Middle River Sanatorium, Hawthorne, Wisconsin.

** Former Superintendent and Middle Director, Middle River Sanatorium, Hawthorne, Wisconsin.

could be identified, and no tubercles or malignancy was found.

Left facial paralysis was noted immediately on the patient's recovery from the anesthetic. As soon as the induration about the wound subsided, an active program of physiotherapy was started. This included facial massage, electric stimulation of the nerve, and support of the face with a sling and hook in the corner of the mouth and scotch tape slings under the lower eyelid. Within two weeks, recovery of the function of the nerve began; and in less than three months it was practically complete.

With such rapid return in function of the facial nerve, it was apparent that the nerve must have been traumatized by retraction rather than by severance. Because the relationship of the sinus tract to the facial nerve has been found to be variable and because of the ease with which the nerve can be injured by retraction, we would recommend a different approach from that described by Rankow and Hanford. When it is apparent that the sinus tract is passing anterior to the posterior belly of the digrastric muscle toward the external auditory canal, we would recommend extending the incision onto the face behind the angle of the mandible and just anterior to the tragus. A flap of skin and subcutaneous tissue should be raised and the seventh nerve identified. Then the tract can be dissected up to the cartilaginous portion of the external auditory canal without danger of injuring the nerve.

Another important point illustrated by this case report is that a diagnosis of tuberculosis without bacteriological proof is always on unsure grounds, and certainly it is usually unwise to treat a lesion such as this with specific antituberculosis drugs without bacteriological proof of the etiology. Also, it is worth emphasizing that an anomaly of the branchial clefts should always be included in the differential diagnosis of any recurrent swelling or draining sinus in the lateral portion of the neck.

Summary

A case is reported in which a first branchial cleft cyst presenting in the neck had been treated unsuccessfully for 28 years as tuberculous cervical lymph nodes but was cured by surgical excision. A surgical approach similar to that used for radical parotid surgery is recommended. The incision starts anterior to the tragus and runs behind the angle of the jaw into the neck to include the fistulous opening.

Duluth Clinic.

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SUMMER CAMP FOR DIABETIC CHILDREN AT LAKE GENEVA

For the seventh season, a summer camp for diabetic children will be opened at Holiday Home, Lake Geneva, Wisconsin, from July 17 to August 7, under the auspices of The Chicago Diabetes Association, Inc.

In addition to the regular personnel of the camp, there will be a staff of resident physicians and dieticians trained in the care of diabetic children. This staff is furnished by The Chicago Diabetes Association.

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Clinicopathologic Conference

Sponsored by the Section on Pathology, State of Wisconsin Medical Society
Guest Editor: Edward Birge, M. D.

REPORT OF A CASE*

The patient, a 65-year-old, white male had been followed as an outpatient by members of the house staff. He had a long-standing hypertensive and arteriosclerotic heart disease, grade II. He had been on a low salt diet, ammonium chloride, and digitoxin, 0.2 mg. daily, and was able to do his daily work as a painter with few complaints. He was last seen about two months prior to his admission when he was given penicillin therapy as a prophylactic measure during dental extraction. The extraction had been uneventful. The morning of admission the patient had a sudden onset of severe substernal pain. Numbness in both arms, cold sweats, weakness, and dyspnea occurred. None of these symptoms were relieved by rest in bed. The patient was sufficiently disturbed to have himself brought to the hospital, and he was seen about an hour after the onset of the symptoms.

Physical Examination—The pulse rate was 86 and irregular, the blood pressure 220/110, the respirations 14 and regular. The patient was a well-developed, well-nourished, white male. His color was ashen gray, the skin was cool and moist, and he appeared acutely ill. Examination of the head and neck showed no abnormality. The lungs were clear. The heart was greatly enlarged. Heart tones were fair. There was a systolic murmur, grade II, heard over the apex. The liver was enlarged and could be felt 2 fingerbreadths below the costal margin. The edge was smooth. The spleen could not be felt. No other masses were felt. The extremities showed a trace of pitting edema. The rectal examination was not done due to the acute illness. Neuromuscular examinations were negative. There was no nuchal rigidity. The patient was placed on oxygen by nasal catheter. He was given ¼ gr. morphine immediately and 1½ gr. papaverine. An electrocardiogram was ordered but apparently was not done. The patient expired unexpectedly about three hours after admission. No laboratory work was done.

* From Milwaukee Hospital.

Clinical Discussion

Dr. L. R. Schweiger: The case to be discussed this morning perhaps is made easier and perhaps more difficult in that the history and physical examination are somewhat limited and by the fact that the patient survived for only three hours after his admission to the hospital. The past history refers to the hypertension and arteriosclerotic heart disease and strongly suggests that the present episode represents a cardiac lesion. The patient had been in chronic heart failure which had been sufficiently under control by therapy so that he was able to continue his daily work as a painter without too much difficulty. There is no note made on his cardiac rhythm during his periods of outpatient observation.

Dr. H. H. Mayer: He would occasionally have to take off from work and then resume on a part-time basis. There was no auricular fibrillation.

Doctor Schweiger: There was no history of myocardial infarction. The next item of importance is the reference to the dental extraction for which the patient was given penicillin. No reason was given for its use. It is not a routine measure in dental extraction. A patient with heart disease may not need it. Arteriosclerotic valves may not need it. There may be some specific reason why this patient needed penicillin, maybe a rheumatic factor.

Two months elapsed between the dental extraction and the patient's admission to the hospital. There is no description of any particular symptoms during this period, although that does not exclude the possibility that the patient may have had subacute bacterial endocarditis resulting from the dental extraction in the presence of a diseased valve. However, he was given penicillin before and after the dental extraction, which is one of the successful methods in preventing subacute bacterial endocarditis, so I think we can exclude the possibility of this condition. Furthermore, the nature of his illness just before

admission, characterized by the sudden onset of rather severe substernal pain, would not relate to the possible subacute bacterial endocarditis except in the rare situations where a vegetating lesion on the aortic valve might have compromised the coronary arteries. The main event appears to be the sudden onset of rather severe substernal pain with numbness in both arms, cold sweats, weakness, and dyspnea, none of which were relieved by rest in bed. An important finding on physical examination is that the heart rate was 86 and irregular. It would have been better if some opinion had been expressed as to the nature of the irregularity. In a man with cardiac enlargement and long-standing hypertensive heart disease, auricular fibrillation is not uncommon. Whether the patient's irregularity represented controlled auricular fibrillation resulting from the digitalis which the man had been receiving or whether it meant frequent premature beats at one time or another, one cannot say. It is important that after the onset of the illness and at the time of admission, the patient's blood pressure was 220/110, respirations 14 and regular, pulse 86 and irregular, and color ashen gray, and that he appeared acutely ill. Therefore, he presented the manifestations of a shocklike state, notwithstanding that the blood pressure was maintained at a hypertensive level.

In the differential diagnosis of an acute episode of this kind, one must consider pulmonary embolism. Its occurrence in cardiac patients is very common, probably more frequent than we can recognize. It is usually associated with transient and mild symptoms and signs which may be overlooked easily. In the occurrence of massive pulmonary embolism—and the lesions would have to be considerable in order to create a dramatic episode of this kind—we would expect that the patient would be rather cyanotic. Furthermore, one of the earliest clues in the occurrence of massive pulmonary embolism is a sharp rise in the venous pressure noted in the cervical veins and a sudden drop in blood pressure. This man's blood pressure had been maintained, and this is important. Furthermore, with large pulmonary emboli, it is most unlikely that the respiratory rate would be 14. Cyanosis and tachypnea are more often noted in pulmonary embolism than they are in myocardial infarction. Since this man had been up and around, it would also reduce the likelihood that this was the nature of the illness. The presence of the grade II systolic murmur probably does not mean much in this man. There was some enlargement of the liver, although there was no comment made about tenderness, which, in a congestive liver, is one of the effects which we would be apt to see. There was some pitting edema. The neuromuscular examination findings were normal. There was no neck rigidity. I do not believe that this man had a massive pulmonary embolism.

The next differential diagnosis which we should consider is myocardial infarction. Certainly with the paucity of observations in this short period, I do not think we should exclude the possibility of myocardial infarcts. Enlargement of the heart, long-standing hypertension, and an undetermined degree of coronary atherosclerosis make a diagnosis of myocardial infarction possible. The occurrence of shock with the maintenance of elevated blood pressure levels speaks strongly against this. Rarely, hypertensive levels may be maintained for short periods. I have seen one case in which the hypertensive levels were maintained for as long as 24 hours, but it is the exception rather than the rule. Therefore, although we should consider the possibility of acute myocardial infarction, it is not my first choice.

There are several other unusual situations which are associated with pain in the chest, but there are not enough features described for this patient to seriously consider them. Two of these possibilities are rupture of an aneurysm of an aortic sinus and subacute bacterial endocarditis causing embolism. However, these are quite rare.

The most serious consideration in my mind is the possibility of a dissecting aneurysm. Such aneurysms are associated with hypertension in about 80 per cent of the cases, so this man had one of the etiologies in which a dissecting aneurysm could occur. The sudden onset of severe chest pain is typical. If there is any one feature which is characteristic, it is pain. The site of pain is usually the chest or upper abdomen, and the extension of the pain varies widely, depending upon the arteries which may be involved in the dissection. About 1 per cent of sudden deaths, according to the coronary studies made by Moat in New York, have been found to be due to this ruptured aneurysm.

Dissecting aneurysm is not limited to the elderly. It is much more common in patients

between 40 and 70 years of age; but it has been described in a child of about 12 or 13 months of age, and it is not uncommon in pregnancy. There was a recent report of a dissecting aneurysm which occurred in a mother between 30 and 31 years of age and also in her child; this would suggest that possibly there is a familial tendency or that the condition might be due to the health of the aorta. The characteristic lesion in dissecting aneurysm is cystic necrosis of the media. There are differences of opinion as to what shows first. It appears that a tear in the intima of the normal aorta does not result in the dissection of the media, so it is a prerequisite that there be disease of the media before dissection can occur. On the other hand, cystic medial necrosis is often described in aortas in which dissection has not occurred, so apparently there is more than one factor necessary before this lesion can develop. The maintenance of blood pressure after the onset of severe pain and shock is a fairly characteristic feature of dissecting aneurysm. The majority of these patients die almost immediately or in a matter of hours. Some studies suggest that 5 to 10 per cent survive the initial episode only to die soon after as a result of the underlying heart disease or as a result of the superimposed secondary dissection of a preaortic insufficiency. There are no references in our protocol to other manifestations which the disease takes, such as involvement by dissection of the carotid artery with coma or confusion, involvement of the anterior spinal artery with paraplegia, or involvement of peripheral arteries with ischemic pain. On the basis of the data available, my diagnosis in this case is dissection of a sclerotic aorta, probably with rupture into the pericardium and acute tamponade. The rupture is usually into the pericardium, although it may be into the left pleural space, mediastinum, or abdomen and retroperitoneal tissues. While the amount of blood in the pericardium may be large, it does not take much to make a cardiac tamponade. Falling blood pressure may be seen when tamponade becomes severe enough. In dissection before tamponade occurs, blood pressures are maintained. The chest pain may be confusing. However, the electrocardiogram generally remains normal and does not manifest the changes of acute myocardial infarction.

Dr. J. W. Bookhamer: Would you say that you would get immediate electrocardiogram changes in myocardial infarcts?

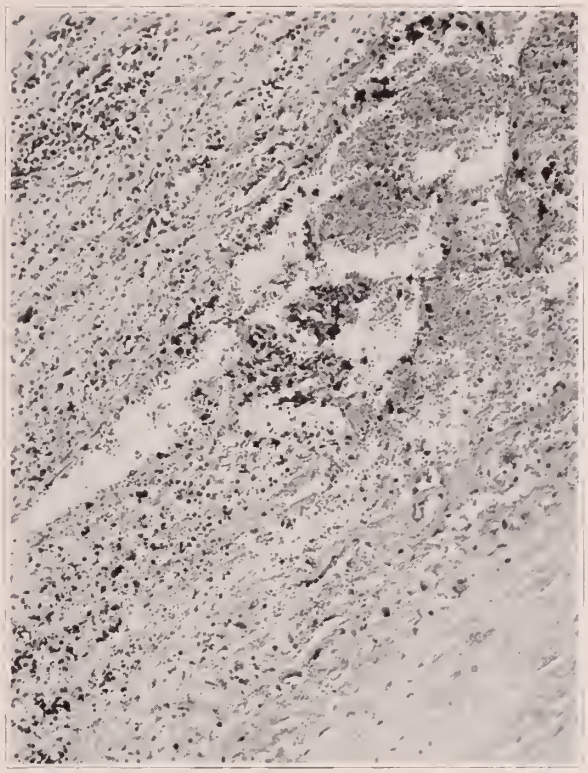

Fig. 1—Section showing hemorrhage in the aortic wall (X 130).

Doctor Schweiger: You would more likely than not.

Dr. Owen Royce: Usually the relatively small infarcts are the ones which take days to show.

Dr. E. R. Daniels: Do you think that the pain in this case is the type that might be of a thoracic origin?

Doctor Schweiger: Yes.

Dr. H. W. Hefke: Could one have a dissecting aneurysm without pain?

Doctor Schweiger: Probably not.

Necropsy Findings

Dr. E. A. Birge: Doctor Schweiger has covered the case very well and has left me little to say. The patient did have a dissecting aneurysm (Fig. 1) which ruptured into the pericardial sac, producing tamponade and death. The dissection began in the ascending aorta at a point about 3 cm. above the aortic ring. It dissected down into the pericardial cavity. At the time of autopsy I found about 350 cc. of fresh clotted blood in the pericardial cavity. There was no evidence of organi-

Fig. 2—Aorta. Note concentration of inflammatory cells in the lower and middle portions of the aortic wall (X 40).

Fig. 4—Lymphocytic infiltration of the aorta (X 180).

Fig. 3—Lymphocytic infiltration of the aorta with some hemorrhage. Small giant cell present in the upper left corner (X 100).

zation of the clot. The other anatomical lesions were those which one associates with long-standing arteriosclerotic and arteriolar sclerotic heart disease. The heart was moderately hypertrophied, with some thickening of the aortic valves. The aorta showed a moderate loss of elasticity, which one would expect in a man over 60. The surface of the aorta was generally smooth except for a few atheromatous plaques. There was no calcification.

The most striking changes were found in the microscopic examination of the aorta. The aorta showed considerable cystic medial necrosis (Fig. 2). The elastic fibers were separated by a material which takes a bluish stain in the H & E preparations; the nature of this material is not known. One finds medial necrosis in many people who die without evidence of dissecting aneurysm, so some other factor is necessary to produce the aneurysm. Hypertension alone does not seem to be the answer either. It takes a tremendous amount of pressure to rupture a normal artery; a purely mechanical blowout on the basis of hypertension alone does not seem possible. Therefore, to have a dissecting aneurysm, one should have an elevated blood pressure

and cystic medial necrosis, plus something else. Further examination of the microscopic sections reveals that the additional factor in this case was considerable inflammation. This inflammation consisted largely of lymphocytes. It was adventitial and perivascular in character. Inflammation is not seen in cystic medial necrosis (Figs. 1, 2, and 3). In this case the inflammation resembled that seen in syphilis. Originally the inflammation was thought to be due to syphilis even though the patient had a negative serology and no clinical evidence of the disease.

Since this patient died, we have had another similar case. Study of the latter case has led us to what I believe is the correct interpretation of this inflammatory lesion; namely, a manifestation of giant cell aortitis. Doctor Carlson first called my attention to this fact, and I will ask him to elaborate on this point.

Dr. D. J. Carlson: Aneurysms of the aorta secondary to giant cell aortitis are rare. In fact, giant cell aortitis is an uncommon lesion. In 1937, Sproul and Hawthorne[1] described two cases of chronic diffuse mesaortitis which they felt were not luetic, tuberculous, rheumatic, or mycotic. In 1950, Magarey[2] described a case of dissecting aneurysm of the aorta with rupture secondary to giant cell aortitis. Giant cell aortitis is a form of necrotizing vascular disease comparable to temporal arteritis. The pathology and pathogenesis are the same as in temporal arteritis.[3] Giant cell aortitis, like other necrotizing diseases, is most probably a manifestation of altered tissue reaction or allergy.[4] It is interesting that both the patients we have seen were given penicillin in the immediate and remote past. The high tissue antigenicity of penicillin is unquestioned, and its association with acute necrotizing angiitis has been pointed out many times. Whether other arteries in this case showed giant cell arteritis is not known. In our cases and in those reported by others, the peripheral arteries were not examined, primarily because the lesion was not suspected at the time of autopsy.

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UNIVERSITY OF WISCONSIN INSTITUTES RESEARCH UNIT FOR STUDY OF AMYOTROPHIC LATERAL SCLEROSIS

Physicians Urged to Refer Patients for Evaluation

A research unit for the study of amyotrophic lateral sclerosis and allied disorders has been established at the University of Wisconsin Medical School. It is supported and financed by the Detling Foundation and is currently under the leadership of Dr. Peter L. Eichman. Participating in the study are: Dr. P. Settlage and graduate student R. P. Bunge in the Department of Anatomy, Dr. G. ZuRhein of the Department of Pathology, and Drs. Hans H. Reese and Henry A. Peters of the Department of Neuropsychiatry.

The primary purpose of the study is an advance in the knowledge of this clinical disorder, its possible etiologic mechanisms, and the use of the various therapeutic measures. Arrangements have been made for the evaluation of patients suspected of having this disease. Patients may be seen as outpatients for immediate evaluation, though admission to the hospital for detailed clinical studies is carried out in the usual manner for hospitalization to the University Hospitals at Madison 6, Wisconsin.

If you have patients with the spinal form with its muscular atrophy, fasciculations, and spastic weakness of the legs, without sensory disturbances, or the bulbar type with dysphagia, nasal speech, fasciculations of the tongue, and the like, we should be most interested in evaluating the syndrome as a part of our program of study for you. Full clinical reports will be sent to you following our examinations. With your cooperation we would also like to offer several types of treatment.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

With what drug has it recently been found possible to reduce the therapeutic-toxic ratio from 60 to 37 in the treatment of congestive heart failure?

The ratio between digitalizing dose and toxic dose reflects the margin of safety of a digitalis preparation. For digitalis leaf, digitoxin, and digoxin this ratio has been reported as approximately 60 per cent; *i.e.*, the average digitalizing dose is about two-thirds the average toxic dose. Under comparable conditions, A. Weiss and F. Steigmann[1] of the Cook County Hospital have found that gitalin has a therapeutic ratio of 37 per cent, the average digitalizing dose approximating only one-third the average toxic dose. Digitalization was tested in 29 patients, and 39 maintenance trials at various dose levels were made in 20. In 16 of the former group gitalin was administered after the maximal response to other therapy had proved inadequate; 13 received no other medication before or during digitalization with gitalin. The individual digitalizing dose ranged from 4 to 9.5 mg. (1 to 4 mg., one to three times daily), and the time required for digitalization was 1 to 5 days (average 2.6). The average digitalization period of the 13 patients not receiving other medication was only 1.6 days, but the average total required was 6 mg. One-day digitalization was attempted in 6 patients by giving three variable doses of gitalin every six hours (usually 2 mg. for the first two doses and 1 or 2 mg. for the final dose). Five required 6 mg. and one 5 mg. In all 29, digitalization was obtained without toxicity. In testing maintenance therapy on 20 patients, trial results indicated that approximately 0.5 mg. gitalin is the daily dose most likely to be both adequate and nontoxic. Toxic manifestations occur increasingly as the dose is raised above 0.5 mg., and lower dosage seems to be adequate for fewer patients.

What new, theoretically interesting, approach has been made to the treatment of brucellosis?

M. Ruiz Castaneda and C. Carrillo–Cardenas[2] of Mexico City decided that since brucellosis is difficult to treat because the organisms multiply within certain cells, including the macrophages, and soluble antibiotics are incapable of penetrating the membranes of these cells, the only effective way to eradicate *Brucella* is to introduce the antibacterial agent into the infected cells. A study was made of the use of relatively insoluble particles of oxytetracycline (Terramycin), which, it was hoped, might come in close contact with the organisms by concentration in lymph nodes, spleen, and other organs and direct or indirect phagocytosis of the transported particles of antibiotic by reticuloendothelial cells. Patients with *Brucella melitensis* infection were treated with a series of subcutaneous injections of amphoteric oxytetracycline in amounts not larger than 160 mg. weekly. Each patient received six to seven injections of the precipitated drug for a total dose of 800 to 1,200 mg. Blood cultures were used as the only criterion of cure.

Of two control groups of 44 and 27 patients, respectively, each with 100 per cent positive blood cultures for brucellosis, 47 per cent in one group still had positive cultures after six months' observation, and 70 per cent in the second group had positive cultures after four weeks' observation. Of one treated group of 44 patients with 100 per cent positive blood cultures at the beginning of treatment, none had a positive culture at the end of 10 weeks and 21 per cent had a positive culture after six months. In 24 treated patients, all with positive blood cultures before treatment, there were no positive cultures after four weeks of treatment. In the control patients the course of bacteremia was uninterrupted for a period of two to three months; in the treated patients the incidence of positive blood cultures was only 18 per cent 15 days after the beginning of treatment.

It has not been possible to study this method of treatment in animals because of the difficulty in producing the infection. Animal studies have shown, however, that the antibiotic deposited in a relatively insoluble form is set in circulation dissolved in the plasma but also that particles of it may eventually reach the spleen or other organs, carried by phagocytes.—HARRY BECKMAN, M. D.

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CHEST FILM REPRODUCTIONS NOW AVAILABLE

The Division on Tuberculosis and Chest Diseases wishes to remind all physicians that the State Board of Health is prepared to furnish you with reproductions of 70 mm. films taken of your patients in mobile unit surveys *during the past two-year period.*

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HENRY A. ANDERSON, M. D.
Chairman, Division on
Tuberculosis and Chest
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Society of Wisconsin

A Look at Food Habits of Wisconsin Children

As It Looks to Your State Board of Health

ARE most Wisconsin children having diets good enough to promote their best possible health and growth? What do we really know about their food habits? While malnutrition does not appear to be a major problem in the state, most physicians will agree that borderline deficiencies often are overlooked. We need better methods for assessing nutritional status as well as a better understanding of the relationship of diet to existing health problems. While answers are being sought and better methods of measurement developed, knowledge of food habits may furnish clues that will guide us toward diet improvement.

Many children in Wisconsin are not having diets as good as they might be, considering our ample food supply. This has been borne out by results of diet studies made during the past six years. State Board of Health nutritionists have assisted local groups with diet surveys in 11 counties and three cities. Included in the surveys were more than 7,800 children in the middle grades. Each child recorded all the foods he had eaten at meals and between meals for a three-day period. These records were checked against the basic food groups which provide nutrients recommended by the National Research Council. Fewer than one-third of the diets could be rated "good." The food groups most frequently found to be inadequate or lacking were milk, certain fruits, and vegetables. The same weaknesses were noted in all parts of the state, though they were more marked in some areas than in others.

In the early surveys fewer than half of the children in most areas had three to four glasses of milk daily. However, rechecks in some places this year indicate an increase in milk consumption in certain counties, with 70 to 75 per cent of the children now having a sufficient amount. While this improvement is encouraging, it must be pointed out that 10 to 20 per cent of the children still are having little or no milk. Only one-fourth to one-half of the children surveyed were having a daily serving of citrus fruits, tomatoes (or juices), or other rich sources of ascorbic acid. (One wonders about this as the citrus fruit group is among the popular food groups).

Green and yellow vegetables are the least liked of the food groups. In most areas surveyed less than one-fourth of the children had a daily serving. While these vegetables are not absolutely essential from a nutritional viewpoint, it has been found that diets which lack them are likely to be low in Vitamin A, especially when no vitamin supplements are used. Furthermore, the person who does not eat vegetables is inclined to lean too heavily on breads, cereals, and sweets for "filler," which in later years may cause a problem in weight control. There were many diet records in which potatoes were the only vegetables eaten in the three-day period.

Breads, cereals, meats, and other protein foods seemed to be eaten in more ample amounts than vegetables by the majority of the children. From 66 to 85 per cent had two servings of lean meat or other protein food per day.

Excessive consumption of candy, soft drinks, concentrated sweets, cookies, and cakes, which provide a high percentage of calories in relation to other nutrients, was noted in practically every survey and was more pronounced in cities and villages than in rural areas. Many of the records included as many as 9 to 21 such items in a three-day period; most of these items appeared as between-meal snacks. This is a matter for concern not only because sweets may replace or crowd out essential foods and contribute to dental decay but also because this pattern of eating may be carried over into later years when it is not conducive to weight control.

Some of the tendency to frequent lunching may be due to lack of satisfying meals, especially breakfasts and lunches. There was great variation in the kind and amount of breakfasts. In some areas only 10 per cent of the children were having "good" breakfasts while in other areas 60 per cent of the breakfasts could be rated "good."

Another factor influencing the quality of the diets was the school lunch. There were twice as many good diets in areas known to have good lunch programs at school as in areas where children went home to lunch or ate a carried lunch.

Undoubtedly, the economic factor enters into diet planning. Unfortunately, the surveys contained no information concerning the economic status of families.

It is recognized that dietary surveys have their limitations and that the findings are not necessarily indicative of nutritional status. However, such surveys do present a picture of food practices which is useful in planning educational programs. They also raise questions such as the following which will require further study:

1. Most children in Wisconsin seem to have enough needed foods to prevent the appearance of the more obvious signs of poor nutrition. Is this enough? What is happening to the child on the marginal food intake?
2. Will the poorer diet pattern from school age through adolescence of the 25 per cent or more in the lower ranks of our survey provide a satisfactory nutritive background for pregnancy?
3. Is there a relationship between the growing problem of obesity and poor food habits in childhood?

Physicians play an important role in improving the food habit picture through starting the infant in the right direction and giving attention to maintenance of good eating practices throughout the growth years.—LUCILE K. BILLINGTON, *Supervisor, Nutrition Division.*

RESEARCH FELLOWSHIPS IN FIELD OF MULTIPLE SCLEROSIS AND ALLIED DISEASES

The National Multiple Sclerosis Society has established a limited number of fellowships to encourage promising students and scholars to enter the field of research related to multiple sclerosis and the demyelinating diseases.

Fellowship candidates are free to elect a training institution and sponsor of their own choice. However, all candidates are urged to consider a training program looking toward preparation for a career of research in this broad general area of disease.

Types of Awards:

Postdoctoral Research Fellowships—To be made to qualified candidates holding a doctorate in medicine or in related fields. Afford a basic stipend of $4,000 to $5,000 per year.

Scholars—Appointment as a Scholar of the National Multiple Sclerosis Society to be made to qualified candidates holding a doctorate in medicine or in related fields and who have demonstrated competence in biological investigation. Stipend of $6,000 to $8,000 per year.

Term and Tenure of Fellowships—Usually awarded for one calendar year and may start any time within eight months of date of notification of award. One or two additional years of fellowship support may be requested; total tenure is not expected to exceed three years. Additional years of support are dependent upon terms of original award and upon continued endorsement by sponsor. Applications should be submitted on or before September 1, and awards will be announced in December.

These awards will not be made or continued concurrent with other fellowships except under unusual circumstances. The fellowships awarded are not intended to support the routine clinical training of a resident where the primary aim of the resident is specialty board certification. Fellows or Scholars are allowed to spend a reasonable amount of their time in teaching. A travel allowance of $150 will be allowed annually for travel from home to the sponsoring institution or to medical meetings. Grants of up to $500 may be made to the sponsoring institution, upon application, as reimbursement for costs incurred by the institution incident to the training program.

For further information and application forms, write Harold R. Wainerdi, M. D., Medical Director, National Multiple Sclerosis Society, 270 Park Avenue, New York 17, New York.

MORE AND MORE PHYSICIANS ARE TURNING

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Acute Toxemia of Pregnancy*

THE acute toxemias of pregnancy, preeclampsia and eclampsia, with or without pre-existing vascular-renal disease, ranked second in frequency in the causes of maternal deaths in the State of Wisconsin in a twelve-month period of study.

Preeclampsia and eclampsia is an acute disease peculiar to pregnant and puerperal women, usually occurring in the last trimester of pregnancy and characterized by edema, hypertension, and proteinuria. Eclampsia is the term reserved for those cases progressing to convulsions and/or coma.

In reviewing the maternal deaths caused by toxemia of pregnancy, the Maternal Mortality Study Committee noted several factors common to the majority of cases that probably were significant in these maternal deaths. They are: (1) inadequate prenatal care; (2) lack of recognition of severe preeclampsia; (3) inadequate treatment of preeclampsia and eclampsia prior to termination of pregnancy; and (4) inadequate control and follow-up of the postpartum eclamptic.

1. *Inadequate prenatal care:* Two patients were having convulsions when medical care was sought. Religious resistance to medical care and an illegitimate pregnancy were factors. All but two of the remaining patients had been seen four times or less by a physician during their prenatal course; two waited until the last six weeks before reporting to a physician. In three instances the patient was seen four times, including the initial visit at three months' gestation. Here the physician possibly had not been insistent enough about regular prenatal care.

At present the only satisfactory means of managing eclampsia is its prevention. *In every pregnant woman the likelihood of acute toxemia must be considered from her initial visit.* If there is evidence of pre-existing essential hypertension, renal disease, diabetes, multiple pregnancy, or other medical complications, from history or findings, the greater possibility of acute toxemia must be kept in mind.

Women should be encouraged to seek medical care early in pregnancy. At the initial office visit, the physician should explain the importance of regular prenatal care. For a minimum of adequate care, the patient should be seen every month up to the sixth month, then in three weeks, then every two weeks until the last month, when she is seen every week or oftener.

At the first visit, a complete history and physical examination findings, including pelvic measurements, are recorded. Blood count, serology, Rh factor and blood type are determined and significant abnormalities treated appropriately. Weight; blood pressure; urinalysis; and the occurrence of headaches, visual or gastrointestinal disturbances, and edema should be recorded at each visit. At the initial visit, or subsequently as necessary, the patient should be told she should limit her weight gain to about 20 pounds throughout pregnancy. This is about the weight she will lose when she has had her baby, and anything more she will retain. It should be explained that with excessive weight gain she is more likely to develop "swelling, kidney trouble, and high blood pressure" in the last months of pregnancy, thereby considerably decreasing her chances of getting a good baby and increasing the chances of complications affecting her own health. She should be told that a high protein diet, with plenty of lean meat, milk, eggs, and cheese, along with fruits and vegetables, should be eaten and that with this diet her weight gain should not be excessive. Dietary supplements of vitamins, iron, and calcium should be recommended.

2. *Lack of recognition of preeclampsia and eclampsia:* Failure to recognize the importance of signs and symptoms of preeclampsia when first noted in the office visits, and delay in therapy, were thought to be a factor in some of the maternal deaths reviewed by the Study Committee.

The first sign of preeclampsia is usually a sudden excessive weight gain. If this occurs in the first two trimesters, faulty eating habits are probably being followed, and the patient should again be instructed about her diet. A sudden excessive weight gain in the last trimester is more serious. It is due, usually, to water retained in the tissues. Edema may or may not be present. Edema of the

* Prepared for the Study Committee of the Wisconsin Maternal Mortality Survey by R. J. Sanderson, M. D., Beloit.

hands, face, and body is of more serious significance than that of the feet and legs, though the latter usually appears first. An elevation of the blood pressure is seen in developing preeclampsia. A blood pressure of 140/90 is considered maximum in normal pregnancy. A rise of 30 mm. Hg systolic or 20 mm. Hg diastolic is probably a better indication of preeclampsia. A blood pressure of 160/90 or above indicates a serious condition in acute toxemia. At times a blood pressure of 140/90 may mean a very sick patient with impending convulsions. Albumin in the urine is present in preeclampsia or eclampsia, the amount corresponding to the severity of the disease. In the severe stage, casts and red blood cells may appear in the sediment. Renal function test results are normal in early preeclampsia. Blood chemistry studies show little change in mild preeclampsia. A rise in uric acid may be present in the severe forms of the disease. In severe toxemia signs of renal failure may be present.

The symptoms of early preeclampsia may be few or absent. Headache, usually frontal, is frequently noted first. Visual disturbances such as double vision and spots before the eyes are common. Blurring or complete loss of vision may develop suddenly. Epigastric pain, especially of the girdle type, is of serious significance. These symptoms developing after previous signs mean a sick patient with possible impending eclampsia.

3. *Inadequate treatment of preeclampsia and eclampsia:* Treatment of preeclampsia depends on several factors—severity of the disease, rate of progression, and underlying vascular renal disease. Each case must be individualized. Whether the disease is mild or severe will determine if there is sufficient time for treatment and expectation of improvement so that the pregnancy may be continued. In mild cases, with the first evidence of rapid excessive weight gain, indicating water retention, the patient should be instructed to eliminate salt, salty foods, milk, cheese, baking soda, antacids, and other medications or food containing sodium from her diet. The pregnant woman is not able to excrete sodium and water as well as the nonpregnant woman. Elimination of retained fluid is the primary object in treatment. Increasing the daily rest periods, and administering mild sedatives and ammonium chloride for its diuretic effects are indicated. Water may be taken in amounts necessary to satisfy the patient's desire. With an increase in edema, weight gain, and a rising blood pressure approaching 140/90, the patient should be hospitalized in spite of protests that she feels well. A few days in the hospital on a regime of bed rest, mild sedation, and a low sodium diet of 200 mg. daily may emphasize to the patient the foods she should have and the manner in which she should live more effectively than all the sincere advice in the office. Blood counts, serum protein, uric acid, urinalysis, blood pressures, daily weight, and intake and output should be obtained and the trends of the disease determined. If improvement is noted, a close follow-up at home may be tried, with the patient continuing her hospital type of life.

In considering how long a patient with mild preeclampsia should be allowed to continue her pregnancy, it is well to remember that, if prolonged, it may have a more permanent effect on the patient's vascular and renal system than if it is of severe but short duration. If the preeclampsia worsens in spite of proper therapy, or if it is severe when first seen, the pregnancy must be terminated if eclampsia is to be prevented. This obstetrical emergency demands close observation by the physician and nursing staff of symptoms, blood pressure, and urinary output. A short period of stabilization by medical treatment if the course has been fulminating is indicated. With rapid progression of the disease from onset, the duration of the treatment will be less. In addition to bed rest, low sodium diet, diuretics, and sedation with barbiturates, magnesium sulfate may be given intramuscularly in doses of 5 to 10 cc. of a 50 per cent solution. It may be repeated every six hours. It is effective in lowering the blood pressure and may be helpful temporarily for a few hours or days in getting the patient in better general condition. Other hypertensive drugs of the veratrum viride group are being used. One should be cognizant of their dangers and remember that *lowering the blood pressure does not cure the disease.* Glucose, 5 to 10 per cent in water, should be administered in moderate amounts to supply calories and enough fluids for renal function and to encourage urinary output. When the condition of the patient is bettered, the method of terminating pregnancy depends on the condition of the cervix. If it is "ripe," partially effaced, not over 2 cm. long and 1 to 2 cm. dilated, rupture of the membranes to initiate labor should be done if there is no obstetrical contraindication. In a

patient not near term, and often in a primipara, the cervix will not be "ripe." Cesarean section is the method of terminating the pregnancy with less chance of eclampsia developing.

The eclamptic patient should be hospitalized as soon as possible. If she is having convulsions or has had convulsions, morphine may be given in 15 to 30 mg. (¼ to ½ gr.) dosage initially to control the convulsions. The patient should be placed in a darkened private room. A retention catheter is inserted for measuring output accurately and the patient sedated with 5 to 10 cc. of a 50 per cent magnesium sulfate solution intramuscularly initially and every 4 to 6 hours as needed. Barbiturates and/or paraldehyde, 10 to 20 cc. in 30 cc. of olive oil, as a retention enema, should be given to control restlessness. Blood pressure should be followed closely. Oxygen should be available for administration during and after convulsions, and there should be a suction apparatus for removal of excessive fluid in the mouth and pharynx. A mouth gag should be at the bedside for use to prevent injury to the tongue and cheeks in convulsions. Glucose, 5 to 10 per cent in water, is given intravenously to aid diuresis and for its calories. No saline should be administered. As soon as the convulsive state is controlled and the patient relatively conscious, termination of pregnancy should be carried out, either by rupture of the membranes, if conditions are right for it and there is no obstetrical contraindication, or by cesarean section if it is felt that labor can not be induced or the time interval will be prolonged too greatly. It is necessary to have the convulsions under control for at least a few hours before terminating pregnancy. The added stress of labor or section on uncontrolled eclampsia results in increased maternal mortality.

4. *Inadequate control and follow-up of the postpartum eclamptic:* Two postpartum maternal deaths were reviewed by the Committee in its 12-month survey. One of these patients received no treatment because of religious beliefs. The death of the other might have been prevented by closer follow-up of the patient after delivery.

Improvement of the severe preeclamptic or eclamptic patient following delivery usually occurs. However, the patient's condition must be watched closely, as some patients continue to have convulsions or have the first manifestations of eclampsia postpartum. The measures previously set out for the management of severe preeclampsia and eclampsia should be continued. The blood pressure should be stable for at least a week before the patient is discharged from the hospital.

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YOU'LL WANT TO SEE THIS NEW FILM

"Lung Cancer—The Problem of Early Diagnosis" illustrates complete x-ray diagnostic procedure, the value of exfoliative cytology and of bronchoscopy, and an exploratory thoracotomy. The need for periodic chest films as well as prompt action by the doctor is emphasized. (30 minutes)

This sound, color movie and those listed below were produced by the National Cancer Institute and the American Cancer Society especially for use by such professional groups as county medical societies, hospital staffs, and medical students. They may be borrowed from the State Board of Health Film Library, 1 West Wilson Street, Madison, or from the American Cancer Society, 652 East Gorham Street, Madison.

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"Uterine Cancer—The Problem of Early Diagnosis" (21 minutes)

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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Volume 54 JUNE 1955 Number 6

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Temple of the Soul

The physician is held in esteem, not only as a scientist, but also as a servant of God who is privileged to enter with affection into the lives of countless human beings. Witness these remarks:

> "With purity and with holiness I will pass my life and practice my art."
>
> ". . . the care of the sick is a task of love and mercy . . . this has been the underlying philosophy of those who, as a profession, have practiced the art of healing. Following in their footsteps, we shall . . . continue to earn for our profession the blessing of the Great Physician Himself."
>
> "Because one of the greatest medical problems in the United States today is that of mental and emotional illness . . . mental health becomes automatically a concern of all practicing physicians."
>
> "Does not the physician deal with the body, which is the temple of the soul? And in many instances, how can the body be healed until the thoughts are similarly healed?"

The first quotation is found in the Oath of Hippocrates. The second is from Doctor McCarey, past president of the State Medical Society. The third is from Doctor Hess, president of the American Medical Association. The last is from Norman Vincent Peale, D. D., pastor of Marble Collegiate Church, New York City.

These quotations have a common and important element—a recognition of the spirit role in the practice of medicine. The time is not so distant when the physician's greatest—and often his only—therapeutic tool was a sympathetic mien. The practice of psychosomatic medicine was at its height. It is from this era that the physician receives his great heritage in the art of medical practice. Since that day science has freed the physician from empiricism, but neither it nor time and progress can free him from the professional bonds of love for his fellow man.

When Doctor Hess urges, as he did at the recent A.M.A. meeting in Atlantic City, that the nation's physicians should be the leaders in a campaign to overcome the ravages of mental illness, he is saying that the basic problem in healing moves, as often as not, into the area of faith. It is recognition that sickness and health are not infrequently directly related to emotional reactions and states of mind, many of them proceeding out of the depths of personality.

If the campaign to aid the mentally ill and reduce emotional disturbance has any chance of success, that chance lies in a resurgence of that kind of medical practice which produces harmony of the soul within the body and mind.

A Physician Philanthropy

A refreshing approach to physician giving came out of the State Medical Society's recent annual meeting. Before long the established physician in Wisconsin will be contacted by the "Charitable, Educational and Scientific Foundation Incorporated of the State Medical Society of Wisconsin.

Behind this formidable title is an organization that should please the hearts of many physicians who have sought a philanthropic vent without too many strings. This foundation, approved by the House of Delegates, will be governed by a board of trustees composed of the Council of the Society and elected representatives from each of the 52 county medical societies. It will seek voluntary contributions only from active members of the Society who are over 35 years of age. The amount of the contribution desired will be set annually by the House. Donations will be deductible for income tax purposes, and all contributions will be used for charitable, educational, and scientific purposes in accordance with the intentions of the givers or the best judgment of the board of trustees.

What a boon for the thoughtful and purposeful physician! Here is a means by which he can contribute to the solution of many puzzling scientific and economic questions arising out of modern medical practice. Often they are the subject of much speculation and writing for which there, equally often, exists no adequate factual basis. The very freedom of medical science may depend upon the manner in which these problems are studied and presented to the public.

Consider the opportunities for research in the effect on public health of new drugs and scientific techniques developed during the last 20 years. How do these developments affect frequency and duration of hospitalization?

Studies similar to recent maternal and infant mortality surveys might be conducted with funds received from donations and bequests rather than draining the dues structure or reserves of the Society.

Enlargement of funds for loans to medical students is an obvious need. As in other medical societies, perhaps there is need in Wisconsin for a means of providing grants to disabled physicians or widows of physicians who might otherwise become public charges.

The profession, or certain of its members, might wish to have special studies made in fields for which no other grants are available. It is likely, too, that through this foundation Wisconsin may be able to make a substantial annual contribution to the American Medical Education Foundation for the support of medical schools.

The potentialities of the foundation are almost unlimited. Equally unlimited are the opportunities for individual physician philanthropy through channels wholly controlled by the medical profession.

A High Honor for Doctor Gundersen

The laurels of leadership in the American Medical Association do not come without merit and neither are they worn lightly by those upon whom they are placed. Such is the case with Dr. Gunnar Gundersen of La Crosse, elected this month by the Board of Trustees to be its chairman.

Wisconsin is pleased but not surprised that a Gundersen should rise to this high place in the medical profession. Doctor Gundersen is one of seven sons of a pioneer Wisconsin physician and surgeon. Six of them are physicians. Doctor Gundersen has long evidenced a real responsiveness to the needs of the public and the Medical Society. He has served the Board of Regents of the University of Wisconsin; the Medical School as a preceptor; the State Board of Health as its president; the State Medical Society in numerous committees, as speaker of its House of Delegates, and finally as president in 1942. He was active in the development of Wisconsin Physicians Service, the Blue Shield plan of the State Medical Society. Currently, he is better known for his part in national and international medical affairs. He was named to the Board of Trustees of the A.M.A. in 1948, was chairman of the Joint Commission on Accreditation of Hospitals during its formative years, and is a member of the Council of the World Medical Association.

We extend our best wishes to Doctor Gundersen, our praise to the trustees for their wisdom, and our prophecy to the doctors of America that they will discover the physician from La Crosse to be one of the most capable men in a long time to climb the rungs of A.M.A. leadership.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION

The 33rd annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held August 28 to September 2 at the Hotel Statler, Detroit.

Scientific and clinical sessions will be given August 29, 30, 31, and September 1 and 2. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, annual instruction seminars will be held.

Full information may be obtained by writing to the executive secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

THE MEDICAL FORUM

MEDICAL ASSISTANTS FORM STATE ORGANIZATION

W. C. White Named Assistant Secretary

To Act as Coordinator of Blue Shield Activities

Madison, June 1.—William C. White, Jr., formerly of Park Forest, Illinois, has joined the staff of the State Medical Society of Wisconsin as assistant secretary.

In his new position, Mr. White will be responsible for coordinating activities in Wisconsin Physicians Service, the Blue Shield Plan of the State Medical Society of Wisconsin.

FORMER ACTUARY

For the past three years, Mr. White has been associated with Carl A. Tiffany & Co., consulting actuaries of Chicago. The Tiffany firm has served the Wisconsin Physicians Service as consulting actuary and underwriter for several years.

Mr. White is a native of Decatur, Illinois, and attended James Millikin University in Decatur and the Illinois Institute of Technology.

BLUE SHIELD EXPERIENCE

Following World War II, he was employed as office manager and comptroller of the Decatur Hospital Service Corporation (Blue Cross). He was appointed managing director of the plan in 1947. For a period of nearly four years, he served as assistant to the comptroller and sales manager for Illinois Blue Cross and Illinois Medical Service.

He has been active in the National Association of Cost Accountants, American Statistical Association, Junior Association of Commerce and Toastmasters. He is a member of Sigma Alpha Epsilon and, prior to coming to Madison, was elected to the vestry of St. John's Episcopal Church in Flossmoor, Illinois.

W. C. White

Board Asks: Do You Need TB X-ray Films?

Milwaukee, June 5.—Physicians interested in obtaining reproductions of films taken of patients by mobile units of the State Board of Health during the past year should make their request to the board as soon as possible.

The House of Delegates asked that Wisconsin doctors cooperate with the State Board of Health in evaluating the worth of a service to supply physicians with reproductions of x-rays taken by the mobile TB units. To date, the response has been disappointing; and the service can hardly be continued at state expense unless greater use is made of it.

TB COMMITTEE REPORT

The House also endorsed the report of the Division on Tuberculosis and Chest Diseases of the Commission on State Departments which emphasized that family physicians should not be influenced by public pressures for ambulatory care of the tuberculous.

The division, under the chairmanship of Dr. H. A. Anderson, Stevens Point, emphasizes that ambulatory therapy for tuberculosis is justified only after the contagious condition has been arrested and then only in carefully selected cases with constant and close medical supervision.

Milwaukee, June 6.—More than 250 secretaries, nurses and technicians employed by physicians attended the first annual meeting of the Wisconsin State Medical Assistants Society in Milwaukee, June 4–5.

The women represented physicians' offices in more than 30 counties of the state. They met to form a state organization to provide educational services for its members and a means of helping the members to provide more efficient service to the profession and the public which they serve.

The Medical Assistants Society has been assisted in its formation by the Council on Medical Service of the State Medical Society and has received financial aid from Wisconsin Physicians Service, the Blue Shield Plan of the State Medical Society, and Surgical Care of the Medical Society of Milwaukee County.

NATIONAL TREND

The organization in Wisconsin is part of a trend across the country for employees of physicians to establish organizations which provide fellowship and cooperation among their members and work closely with state medical societies in many projects. Similar organizations have been established in Michigan, Oklahoma, Missouri, and other states. All are working closely with state and county medical societies.

DEFINE MEMBERSHIP

The Wisconsin State Medical Assistants Society adopted a constitution and by-laws which provides that active members in the society shall consist "of any eligible person actively employed in the office or laboratory of a member of the State Medical Society of Wisconsin or any eligible person employed in teaching, technical or administrative capacity in hospitals (approved by the Joint Commission on Accreditation of Hospitals) and medical laboratories in the State

(Continued on page 327)

PHYSICIANS URGED TO AID IN SEARCH FOR MULTIPLE SCLEROSIS VICTIMS

Madison, June 1.—A nationwide search for victims of multiple sclerosis is being conducted by some 2,750 JayCee chapters, including those in Wisconsin. Arranged in cooperation with the National Multiple Sclerosis Society and its 70 chapters, the "search" will attempt to reach an estimated 250,000 unknown multiple sclerosis victims and put them in touch with the national society, according to Lucian G. Schlimgen, Jr., chairman of the Multiple Search for Multiple Sclerosis program of the Madison JayCees.

Physicians are urged to cooperate in the search by advising the National Multiple Sclerosis Society of the names and addresses of all multiple sclerosis victims. Victims and their relatives are urged to do the same thing. The identity of any person reported to the society will be kept fully confidential.

The JayCees report that, because neither the cause nor cure for multiple sclerosis is known, medical research teams are seeking the identity of thousands of victims. It is hoped that information which can be provided by these patients, their doctors or relatives will verify or rule out certain research approaches.

In addition, according to Mr. Schlimgen, contact with the National Multiple Sclerosis Society will provide the inquirer with the latest authenticated information on multiple sclerosis.

Dr. Hans H. Reese, Madison, is chairman of the Medical Advisory Board of the National Multiple Sclerosis Society and will provide additional information for any physician interested in the search for victims.

Mr. Schlimgen reported that the JayCee group is interested in the multiple sclerosis program because the disease is reported to strike 1 in every 400 young adults. It strikes heaviest in the JayCee age group from 20 to 35, he said.

Physicians are urged to send in the names of any multiple sclerosis patients to whom they would like to have information sent about the disease. The coupon printed in the next column may be used for this purpose, or the patient may be advised to personally write for information.

Survey Facilities for Chronically Ill

Check Nearly 800 Places Housing 18,000 Persons

Madison, June 1.—A state-wide survey of existing facilities rendering care to the aged, infirm or chronically ill will be completed by the end of June, according to the State Board of Health.

Nearly 800 places now giving sheltered care to an estimated 18,000 aged, infirm or chronically ill persons will be visited personally by 7 temporary and 3 permanent registered nurses.

The survey will include not only nursing homes, homes for the aged, chronic disease hospitals and related facilities, but also general hospitals to determine the number of long term care patients in the hospitals.

The survey, the most comprehensive yet undertaken, will produce realistic information concerning the need, on an area basis, for facilities for this group of individuals, who for various reasons may not be cared for in their own homes. Visits will be made to all types of homes, regardless of size and bed capacity, now offering care to the aged.

The survey is primarily being undertaken to enable Wisconsin to qualify for certain federal grants-in-aid. However, it will also obtain data of tremendous value in preparing a sound plan for such facilities based upon relative need.

Urge Wider Use of Cancer Education Data

Milwaukee, June 4.—Films and other scientific material, available from the American Cancer Society, should be used by county medical societies and hospital staffs for their scientific programs, declared the Committee on Cancer in its report to the House of Delegates, approved at the annual meeting.

The committee, under the chairmanship of Dr. R. P. Welbourne, Watertown, also stressed the importance of the regional cancer conferences for physicians and dentists as a means of strengthening interprofessional responsibility for cancer detection.

Study to Be Made of Educational Television

Milwaukee, June 5.—Constant change in postgraduate medical education has prompted the Council on Scientific Work to initiate a study of television as a teaching device, the House of Delegates learned.

The report of the Council, adopted by the House, said that meetings will be held during the next year with representatives of the two medical schools and others to determine the possibility of providing hospital staffs and other groups with television programs.

The House voted to continue the circuit teaching programs which the Council, under the leadership of Dr. P. A. Midelfart, Eau Claire, has sponsored. The report noted that 400 Society members have attended the 10 programs held since the 1954 annual meeting.

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_____
(City, State)

Requested By: Patient ☐ _____
Physician ☐ (Signature)
Relative ☐
(Check applicable box) _____
(Address)

PHYSICIANS RESPOND WELL TO CIVIL DEFENSE NEED

Madison, June 1.—County medical societies are giving strong support to Wisconsin's civil defense program.

The most recent developments include appointment of 29 physicians to serve as captains and deputy officers of civil defense mobile medical terms in various areas of the state.

The Wisconsin program calls for two physicians on each team plus 27 others, including nurses, dentists, medical corpsmen, first aiders, stretcher bearers, clerks, and a business manager.

Nearly 100 mobile teams need to be established to give Wisconsin an adequate medical defense program. Nearly one-third of these are well into the process of organization and training.

The Lake Geneva Mobile Medical Team under Dr. E. D. Hudson and Dr. B. C. Hindall has done an outstanding job in organizing team personnel. There is a complete complement of personnel for each of the 29 physicians on the team and a full set of alternates for each position. These are listed on an organizational chart with office and residence addresses and telephone numbers so that they may be reached easily in an emergency.

Mr. Theodore Noe, assistant co-director of health services in civil defense, Madison, has been working closely with these societies in developing their programs and providing them with information and materials on which to train and organize the teams.

Recent Appointments to Medical Team Staffs

Medical Team	*Captain*	*Deputy Officer*
201, Kenosha	C. M. Creswell, M.D.	R. W. Ashley, M.D.
202, Kenosha	G. C. Schulte, M.D.	H. C. Kappus, M.D.
203, Kenosha	H. L. Schwartz, M.D.	J. T. Garren, M.D.
204, Kenosha	A. M. Rauch, M.D.	L. H. Lokvam, M.D.
207, Delavan	J. E. Martin, M.D.	W. C. Woods, M.D.
211, Kenosha	C. E. Pechous, M.D.	J. B. Pearson, M.D.
212, Lake Geneva	E. D. Hudson, M.D.	B. C. Hindall, M.D.
213, Kenosha	J. P. Graves, M.D.	D. N. Goldstein, M.D.
218, Racine	C. R. Newman, M.D.	Richard Minton, M.D.
324, Waupun	J. A. Peterson, M.D.	
326, Oshkosh	S. J. Graiewski, M.D.	
327, Oshkosh	T. S. Lynch, M.D.	
328, Oshkosh	F. A. Brei, M.D.	
329, Oshkosh	W. V. Hahn, M.D.	
330, Menasha	P. T. O'Brien, M.D.	
331, Menasha	R. A. Jensen, M.D.	
335, Neenah	G. O. Horn, M.D.	
336, Neenah	R. G. Bonfiglio, M.D.	

Medical Society to Exhibit at State Fair

Madison, May 26.—A unique health educational display named "HEALTHLAND" at the Wisconsin State Fair will feature an exhibit by the State Medical Society of Wisconsin.

The Society will be one of nearly 25 agencies which have joined hands in an effort to tell the Wisconsin public about their efforts in the field of health improvement. The "HEALTHLAND" exhibit will be housed in the north end of the Wisconsin-At-Work Building. The general theme of the project will be "Working Together to Keep YOU Well!"

Under the sponsorship of the Health Education Committee of the Community Welfare Council of Milwaukee County, the various agencies have been asked to develop displays employing viewer-participation techniques, health screening programs, demonstrations, and other educational materials.

M.D.'s Urged to Attend Education Conference

Madison, June 1.—Wisconsin physicians who are interested in the state's educational problems are urged to attend the Wisconsin Conference on Education at the Memorial Union in Madison, June 27–28.

The State Medical Society of Wisconsin has designated members of the Division on School Health as its representatives to the conference. They are Drs. E. H. Pawsat, Fond du Lac; A. C. Edwards, Racine; A. H. Heidner, West Bend; W. R. Manz, Eau Claire; F. J. Mellencamp, Milwaukee; and J. R. Schroder, Janesville.

Three Wisconsin physicians are serving on a state-wide committee to lay plans for the conference. They are Drs. W. H. Cantwell, Shawano; Beatrice O. Jones, Racine; and Walton R. Manz, Eau Claire.

This meeting, a preliminary to the White House Conference, will be a work session covering such problems as curriculum, finance, buildings, and teacher supply and demand. Some four hundred Wisconsin citizens are expected to attend.

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Our helpful brochure
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DRS. FULLER AND WASHBURN HONORED RECENTLY WITH LIFE MEMBERSHIP IN STATE MEDICAL SOCIETY

Madison, June 1.—Two Wisconsin physicians have been honored recently with life memberships in the State Medical Society of Wisconsin.

Dr. Robert G. Washburn, Milwaukee, and Dr. Maynard H. Fuller, Green Bay, received the award from the Council of the State Medical Society. They received certificates in recognition of their "high achievements in the ranks of medicine."

Dr. Washburn, a dermatologist, was a graduate of Johns Hopkins University in 1904.

For many years, he served as staff dermatologist for Columbia, St. Mary's and Milwaukee Children's hospitals.

Dr. Fuller, a native of Sharon, Wisconsin, was graduated from Marquette University School of Medicine in 1904. He has specialized in the treatment of eye, ear, nose and throat diseases.

He has served as president and secretary of the Brown–Kewaunee–Door County Medical Society.

He took postgraduate work in Chicago, New York and Berlin.

Dr. M. H. Fuller, Green Bay (left), receives a life membership certificate from the State Medical Society at a recent meeting of the Brown–Kewaunee–Door County Medical Society. Observing the presentation were (left to right): Dr. Ervin L. Bernhart, Milwaukee, president of the State Medical Society; C. H. Crownhart, Madison, secretary; and Dr. G. M. Shinners, Green Bay, secretary of the county society. Dr. Fuller is a specialist in EENT.

"BLACK LIGHT" DEMONSTRATION WARNS OF NEED FOR CIVIL DEFENSE PLAN

Milwaukee, June 5.—The devastating effects of an H-bomb attack in a "critical" area such as Milwaukee could be substantially reduced if an effective plan for evacuation and care of casualties existed to cope with the emergency.

This statement emphasizing the need for active medical participation in civil defense planning was made by Ralph Garrett, director of welfare aspects of civil defense in the regional office of the Federal Civil Defense Administration at Battle Creek, Mich. Garrett illustrated the effects of such an attack with a dramatic "black light" presentation at a special civil defense demonstration for doctors at the annual meeting.

He warned that because of the widespread destruction in such an attack, outlying areas would have to supply additional personnel and facilities to handle the emergency. To do this, a well-coordinated civil defense plan must be organized before the attack occurs.

Garrett pointed out that unless the attacked city had been previously evacuated, the problem would be complicated by the destruction within the city of key personnel and equipment at a time when they were most needed.

Such an evacuation plan has been under study by the Committee on Civil Defense of the State Medical Society which serves as an advisory committee to the state health officer, who is co-director of civil defense health services. In its report to the House of Delegates, the committee said it had assisted in the preparation of detailed plans for first aid, transportation, and hospitalization of casualties resulting from an enemy attack on Wisconsin cities. Dr. Marc J. Musser, Madison, is chairman of the committee.

The House urged all physicians to give full support to the medical aspects of civil defense programs, particularly the mobile medical teams.

AMA FILMS SHOWN TO 1500 IN STATE

Madison, June 1.—During the month of April, 1955, more than 1,500 Wisconsin people saw motion pictures produced and distributed by the American Medical Association.

The film "Operation Herbert" (27 minutes) was shown to nearly 700 people in Beloit, Williams Bay, Cuba City, Marshall, Clintonville, Wausau, Weyerhauser, Milwaukee and Wausau.

The film "Your Doctor" (15 minutes) was shown to about 900 persons in Whitefish Bay, Fredonia, Sturgeon Bay, Iron Mountain, Milwaukee, Irma, Ellsworth, Madison, Weyauwega, and Iron Ridge.

Both films are available upon request to the State Medical Society of Wisconsin or the American Medical Association. The first demonstrates the cost of medical care today as compared to 1937, and the film "Your Doctor" tells what goes into the training of a physician and the practice of medicine in America today.

Chiropractors Adopt Vaccine Resolution

The following article is reprinted from the De Pere Journal–Democrat of May 5, 1955.

Editor, Journal–Democrat:

This is a resolution adopted by the Academy of Orthopathic Spineology at their recent meeting held at Stevens Point on April 23 and 24:

"Whereas: the Salk anti-polio vaccine has been approved and acclaimed nationally, and

"Whereas: this induced immunity has its active scientific value in relationship to the medical school of theory, and

"Whereas: this poses an involvment of several scientific factors as applied to each child or adult as a protective measure, therefore

"Be it resolved, that the Academy of Orthopathic Spineology in the interest of public health and welfare, set forth this resolution as a public document; whereby it be known that congenital or natural immunity resident in each human body is a condition ensuing when defensive substances or antibodies are present in normal and untreated subjects for self assured immunity;

"Further be it resolved, that the Academy of Orthopathic Spineoloby will uphold the rights of the people and assist in avoiding any type of compulsory action by any one healing profession to preserve our American way of life in the pursuit of happiness and health."

This resolution is self-explanatory and sets forth our position relative to immunization. We definitely feel that the public is entitled to know our stand on this vital question and that there is "another side" to it. Also that there is such a thing as "natural immunity" resident in normal people at all times.

The Academy of Orthopathic Spineology is composed of a group of Wisconsin chiropractors for the purpose of perpetual "post graduate" study of the science of chiropractic and its relation to normal health.

I trust you will find this article of sufficient public health value to print it in your good paper.

Sincerely yours,
F. A. Stauber, D. C.
W. De Pere, Wis.

New Anatomy Exhibits Offered by A.M.A.

Madison, June 1.—County medical societies will find a new A.M.A. exhibit series of particular value for health education purposes.

The new exhibits depict the basic anatomy of the human body. Each exhibit will feature life-size, three-dimension models of parts of the body and should prove invaluable as a health education aid.

Society Offers Pamphlet On Medical Schools

Madison, June 1.—The latest information on the production of physicians and the growth of medical schools and their facilities is available in a new 12-page pamphlet upon request from the State Medical Society office, Box 1109, Madison 1, Wisconsin.

Produced by the American Medical Association, the attractive pamphlet describes the record achievements of the nation's medical schools during the past year. It discusses four main phases of medical education in which the 80 approved medical schools in the country now are surpassing all previous records.

MEDICAL ASSISTANTS . . .

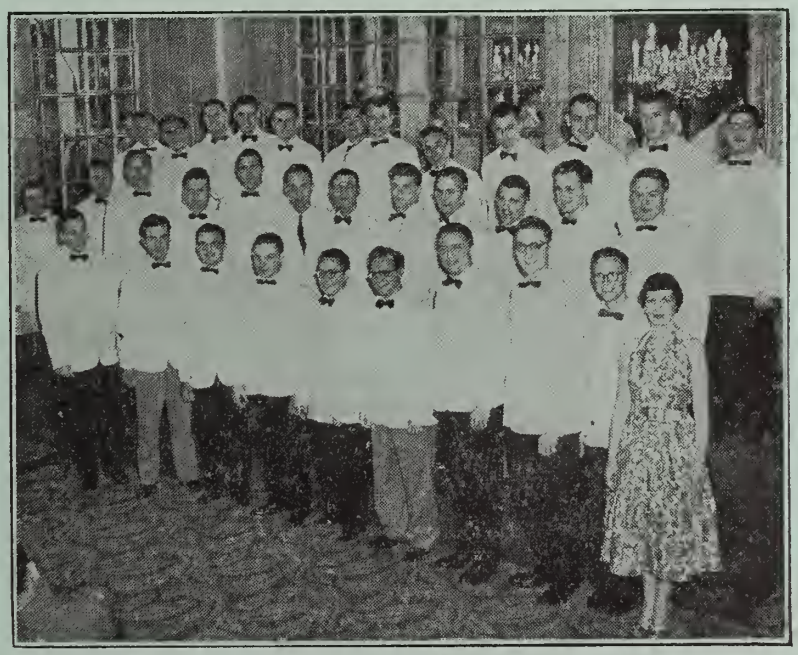
(Continued from page 321)

of Wisconsin." Component local societies may organize a smaller group if there are five or more persons eligible for membership. Dues for active members are $1.00 for the balance of 1955 and $2.00 per year thereafter.

The constitution and by-laws of the new society were approved by the State Medical Society prior to its annual meeting.

MOBERLY SPEAKS

Mrs. Elizabeth Peck, Lansing, Michigan, president of the Michigan Medical Assistants Society, aided the group in establishing the organization in Milwaukee. Professor Russell Moberly, director of the management center at Marquette University, spoke to the group at a dinner on Sunday, June 5. He discussed the role of the medical assistant in providing better medical service by being more valuable to her physician employer. He stressed the necessity for constant alertness, vigilance, and self-improvement on the part of medical assistants if they are to serve well in their positions of trust and responsibility.



The glee club of Marquette University Medical School, one of the few such medical student groups in the country, was featured at the annual banquet of the Student American Medical Association convention in Chicago recently.

The glee club has 36 student members under the direction of Miss Gloria Rodriguez. Lakeside Laboratories, Inc., Milwaukee, sponsored the trip of the group to Chicago.

THE MAN AND THE MYTH

A DOCTOR ILL? To most of us such news comes as a shock. It reveals what we all know but are reluctant to accept: That the doctor too is mortal. And because, in our frailty, we seek a shield against disease and death, we glorify the doctor, invest him with impossible power. Ironically, this legend obscures the basic fact that the doctor is a man who must earn his daily bread. What is the true picture of the doctor in our society?—a man of hope . . . a man dedicated to easing human suffering? Yes! Yet he is more. *The doctor is an economic unit. He is the man who must compete in the market-place for business, as we all do, whether we deal in pills or pants.* This does not diminish the stature of the doctor. On the contrary, it releases him from the awful burden of saintliness. It establishes him as a man. Wake him at four in the morning. He is sleepy. Call him from his meals. He is hungry. Summon him from his family. He is lonely. Subject to the laws of biology, he is equally subject to the laws of economics. *The doctor works for a living.* Everyone agrees the doctor is no philanthropist. Nobody expects medical care without paying for it. Yet it would astound us (and the doctors themselves) if we were to tote up the bill the nation's patients owe their doctors and compare it with the bill owed their tailors. Even more outstanding would be the number of hours doctors spend in clinics, hospitals, on calls, for which they receive no payment nor expect any. The doctor deserves no medal for this. But these unpaid bills and freely given hours can be translated into lost income . . . income it would be unseemly for the doctor to insist upon. The legend of the doctor prevents him. It is nothing for a giant to do gigantic things. It is within his nature to do so. But it is something when a man transcends his mortality. And this is the secret of the doctor's stature. As a mere man he must rise above his limitations. *This is the American doctor—a man greater than his myth.*

—Published by Key Corporation (Pharmaceuticals), Miami.

Dr. Paul Purtell, Milwaukee (second from left), 1955 winner of Wisconsin Medical Golf Association's annual tournament, shows trophy to (left to right) Dr. E. L. Bernhart, secretary–treasurer of the association; Dr. Stanley Zawodny, last year's winner; and A. H. Luthmers, association executive secretary. All are of Milwaukee. Tournament was held May 2 at North Hills Country Club.

RUSSIANS MOVE IN ON THE I.L.O.

Admitting Russian delegates to the International Labor Organization has changed the basic policy of the organization in the opinion of William L. McGrath of Cincinnati. McGrath was an American "employer" delegate to the 37th International Labor Conference of the I.L.O. held in Geneva last June.

Because of the I.L.O's covenants embracing sickness benefits and compulsory health insurance, American medicine maintains a keen interest in the organization's activities. In a 20-page report on the conference, McGrath points out that Russia dropped out of the I.L.O. in 1939 but was readmitted this year at its own request.

Since Communist delegates represent their government rather than the free trade associations for which the I.L.O. was founded, McGrath concludes that admitting these delegates "destroys the underlying foundation of the I.L.O."

Problem of the Day

Anyone who thinks that the problems of medical public relations are of recent origin will be interested in the opinions of Dr. Robert Boal of Peoria, Ill., quoted recently in the *Newsletter* of the Illinois State Medical Society. It was back in 1882 when Dr. Boal said:

"The amenities of professional intercourse, and the obligations of medical men toward each other and the public, were perhaps better observed in 1850 than now. Then the doctor, next to the minister, was the trusted friend and counselor of every family to whom he ministered. He shared their joys, soothed their sorrows, and every passing year added to and cemented the attachment and affection between them. Now the doctor is regarded more in the light of a tradesman or mechanic, and is employed from the same consideration that a grocer, tailor, or shoemaker is. The strong ties of gratitude and affection have almost ceased to exist. Relationship is now placed upon a mere commercial basis, and for this the profession is more to blame than the public."

Facts about

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A Medical Student Looks at Blue Shield *

The basic concept (of Blue Shield) is that of insurance which involves what Sir Winston Churchill has called "the magic of averages applied to the salvation of the multitude." It is but natural and logical that any expansion of this principle should be applied to protect the individual against the loss of capital or credit or both as a result of illness. The conditions of its application, however, require much thought.

The problem of how best to utilize the principle is essentially one for resolution by the medical profession because, despite the intrusion of social and economic considerations of a nonmedical nature, the only comprehensive knowledge of the factors of controlling significance in any feasible plan is possessed by the medical profession.

Quite obviously, no other profession or group has had comparable experience with illness, its causes, costs, cures, and effects. The whole interplay of human relationships in respect to illness—actual, feigned, or anticipatory—is under the constant observation of the medical profession to a degree not even approximated by any other body of men.

Medical men, because of their awareness of the problem of the potentially adverse effect of medical costs to the individual and their clear and full realization of the total nondesirability of socialized medicine as an attempted solution of the problem, are morally obligated to use all of the resources of the profession to see that acceptable methods of dealing with the entire problem are successful in the widest possible area and the highest possible degree.

One of the areas yet to be explored fully relates to the fixing of the point at which the advantages of early diagnosis as the result of examinations induced by insurance —which would not be made otherwise—may be offset by excessive or unwarranted demands for medical attention induced by the same factor.

An insurance plan or contract can not change human nature and there will always be individuals who are perverse as well as those who are merely unfortunate, but fortunately the principle of insurance rests on the laws of probability with respect to a group rather than the individuals comprising it.

Thus, it may be possible through safeguards yet to be devised to embrace the risks deriving from defects of character or judgment in the process of insuring against the costs of illness and minimizing its incidence. After all, bonding companies do survive. Certainly, in any event, it will be possible ultimately to determine with reasonable accuracy the point at which insurance ceases to be feasible.

* Excerpts from first-prize essay in contest sponsored by Blue Shield Medical Care plans and the Student American Medical Association. Author: Wilbur C. Pickett, Jr., University of Maryland, Baltimore.

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Society Proceedings

Barron—Washburn—Sawyer—Burnett

Nineteen members of the Barron–Washburn–Sawyer–Burnett County Medical Society met on May 10 at the Elks Club, Rice Lake, to hear a discussion of medical and health insurance programs.

Guest speakers were Mr. Robert F. Froehlke, assistant secretary of Hardware Mutuals Insurance Company, who represented the Health Insurance Council, Stevens Point, and Mr. Paul R. Doege, sales coordinator of Wisconsin Physicians Service, Madison.

Brown—Kewaunee—Door

The last meeting of the Brown–Kewaunee–Door County Medical Society before the summer recess was held on May 12 at the Elks Club, Green Bay.

Dr. E. L. Bernhart, president of the State Medical Society, discussed objectives of his administration; and Mr. C. H. Crownhart and Mr. Robert B. Murphy, secretary and legal counsel, respectively, of the State Society, presented brief reviews of highlights of the Annual Meeting of the Society held in Milwaukee in May. *Drs. L. C. Miller*, Green Bay, and *R. M. Waldkirch*, De Pere, delegates to the House of Delegates of the State Society, reported on proceedings of the House meeting in May.

Mr. Crownhart presented *Dr. M. H. Fuller* of Green Bay with a life membership certificate in recognition of his completion of 50 years of continuous membership in the State Medical Society of Wisconsin.

Sixty members of the society attended the meeting.

Calumet

Election of officers was held at the meeting of the Calumet County Medical Society at the Club Chilton, New Holstein, on April 21. *Dr. F. P. Larme* of New Holstein was re-elected president and *Dr. Kenneth Humke* of Chilton, vice-president, for the new year.

The polio vaccination program was discussed, and Doctor Larme reported on a closed television circuit symposium on the subject of "Management of Streptococcal Infections and Their Complications" which was recently televised to 64 cities in the United States and Canada. Doctor Larme witnessed the program at the Hotel Schroeder, Milwaukee.

Physicians' wives were in attendance at this meeting.

Dane

At the May 10 meeting of the Dane County Medical Society, delegates to the House of Delegates of the State Medical Society reported on actions of the House at its meetings in early May.

Mr. C. H. Crownhart, secretary of the State Society; Mr. Robert B. Murphy, its legal counsel; and Mr. Thomas J. Doran, claims director of Wisconsin Physicians Service, were present to discuss the Blue Shield insurance program and to answer questions that had been raised by members at their April meeting.

Fond du Lac

The monthly meeting of the Fond du Lac County Medical Society was held at the Elks Club, Fond du Lac, on April 28. *Dr. J. C. Yockey* of Fond du Lac arranged for the showing of the film, "Present-Day Treatment of Hypertension," produced under the auspices of the Wyeth Company. Thirty members of the society attended the meeting.

On May 26, members of the society and their wives met at the Republican House in Ripon. Dr. Joseph A. Mussulman, professor of music at Ripon College, addressed the group.

Green

At the meeting of the Green County Medical Society held at the Monroe Clinic, Monroe, on April 12, *Dr. E. V. Hicks* of New Glarus was elected president of the society; and *Dr. F. J. Bongiorno* of Albany was chosen vice-president.

The polio vaccination program was discussed by the members present.

Green Lake—Waushara

Eleven members of the Green Lake–Waushara County Medical Society met at the Hotel Whiting, Berlin, on April 28, at which time *Dr. F. J. Hofmeister* of Milwaukee spoke on "Early Detection of Gynecologic Cancer." Mrs. Rosemary Vahldiek also addressed the group, discussing "Periodic Physical Examinations for School Children."

Jefferson

The Jefferson County Medical Society held its monthly dinner meeting on April 21 at the residence of Mrs. Anna Roehl at Lake Mills.

Mr. Robert Dufour, Milwaukee, executive secretary of the Wisconsin Academy of General Practice, spoke on "The Wisconsin Family Physician."

Kenosha

Dr. F. J. Hofmeister, assistant clinical professor of obstetrics and gynecology at Marquette University School of Medicine, Milwaukee, spoke to the

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1. Ruffin, J. M.; Baylin, G. J.; Legerton, C. W., Jr., and Texter, E. C., Jr.: Mechanism of Pain in Peptic Ulcer, Gastroenterology *23*:252 (Feb.) 1953.

2. Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: A Clinical Evaluation of a New Anticholinergic Drug, Pro-Banthine, Gastroenterology *25*:416 (Nov.) 1953.

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members of the Kenosha County Medical Society on May 10. He discussed the survey of maternal deaths conducted in Wisconsin in 1953 and recommendations for prevention and treatment of obstetric complications.

Delegates to the House of Delegates of the State Society and the Councilor reported on meetings held in Milwaukee early in May. The county society voted to actively support scientific activities in public schools.

The meeting was held at the Elks Club, Kenosha, with 47 members in attendance.

La Crosse

Members of the La Crosse County Medical Society met on May 16 at the La Crosse Country Club to hear a discussion of prepaid medical care insurance. Mr. Robert Froehlke, assistant secretary of Hardware Mutuals, Stevens Point, representing the Health Insurance Council, and Mr. Paul Doege, sales coordinator of Wisconsin Physicians Service, Madison, were the speakers.

Lafayette

At the April meeting of the Lafayette County Medical Society held at the Memorial Hospital, Darlington, *Dr. L. J. Unterholzner* of Blanchardville was elected president. *Dr. Robert Oertley,* Darlington, was named secretary-treasurer.

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Milwaukee

Members of the Medical Society of Milwaukee County heard an address by Dr. Howard Ulfelder of Boston, Massachusetts, at their meeting on April 14 at the Milwaukee Athletic Club.

Doctor Ulfelder is assistant clinical professor of gynecology at the Harvard Medical School and visiting surgeon at the Massachusetts General Hospital. He spoke on "An Optimistic Approach to the Present-Day Status of Cancer of the Cervix."

Outagamie

"Medicine and the Law" was the subject of the joint meeting of the Outagamie County Bar Association and the Medical Society on April 21 at the Elks Club, Appleton. Mr. George E. Hall, staff associate of the legal department of the American Medical Association, Chicago, addressed the group. Fifty-eight physicians and attorneys attended the meeting.

Approval was given to the program of examinations for all fifth and sixth grade school children prior to the next school term. A report was presented by *Dr. H. T. Gross,* medical director of the Community Blood Center, Appleton, in which he stated that facilities for the center were nearing completion.

On May 19, 43 members of the society met at the Elks Club, Appleton, to hear *Dr. Erwin R. Schmidt,* professor of surgery at the University of Wisconsin Medical School, Madison, speak on "Malignant Lesions of the Mouth and Neck." This meeting was preceded by an open house at the Medical Arts Building.

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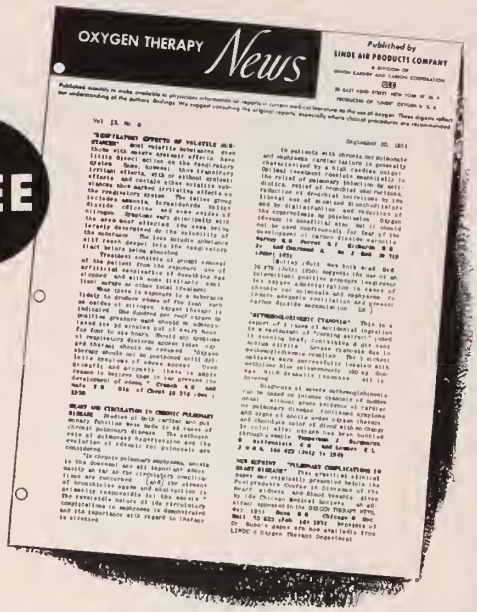

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At their business meeting, members approved the date of October 28 for scheduling a postgraduate program in Appleton. A donation of $150 was voted as a contribution to the Community Blood Center, and approval was given to the appointment of a Committee on Diabetes.

The annual society picnic was held on June 1 with members of the Woman's Auxiliary.

Pierce–St. Croix

The Pierce–St. Croix County Medical Society met at River Falls on April 19, at which time Dr. Samuel Hunter of St. Paul was the guest speaker. His subject was "Surgery of the Heart and Large Blood Vessels."

The polio vaccination program was also discussed.

Polk

On April 21, members of the Polk County Medical Society were guests of *Dr. A. Hohf* of Milltown at the Indianhead Lodge, Balsam Lake. *Dr. R. E. Graber*, district health officer, Chippewa Falls, spoke on polio immunization plans. A round-table discussion followed.

Other business included discussion of chest x-ray and diabetic surveys to be conducted this summer and a review of social security legislation.

Sixteen members were present.

Rock

Mr. Robert Froehlke, assistant secretary of Hardware Mutuals Insurance Company, Stevens Point, representing the Health Insurance Council, and Mr. Paul Doege, sales coordinator of Wisconsin Physicians Service, Madison, discussed prepaid medical care insurance at the May 24 meeting of the Rock County Medical Society. The meeting was held at the Monterey Hotel, Janesville.

Sauk

The Sauk County Medical Society held its regular meeting on May 10 at the Sauk County Home at Reedsburg. Dr. Kathryn Schwerma, Director of Tuberculosis Control for the Division of Mental Hygiene of the State Department of Public Welfare, Madison, spoke on "Control of Tuberculosis in Mental Institutions." Eleven members attended the meeting.

Sheboygan

Members of the Sheboygan County Medical Society met at the Guild Hall, Sheboygan, on May 19 to witness a civil defense program. Registered and practical nurses, nurses' aides, and former nurses were invited to attend.

Colonel George Carnachan, Milwaukee, civil defense coordinator, discussed effects and capabilities

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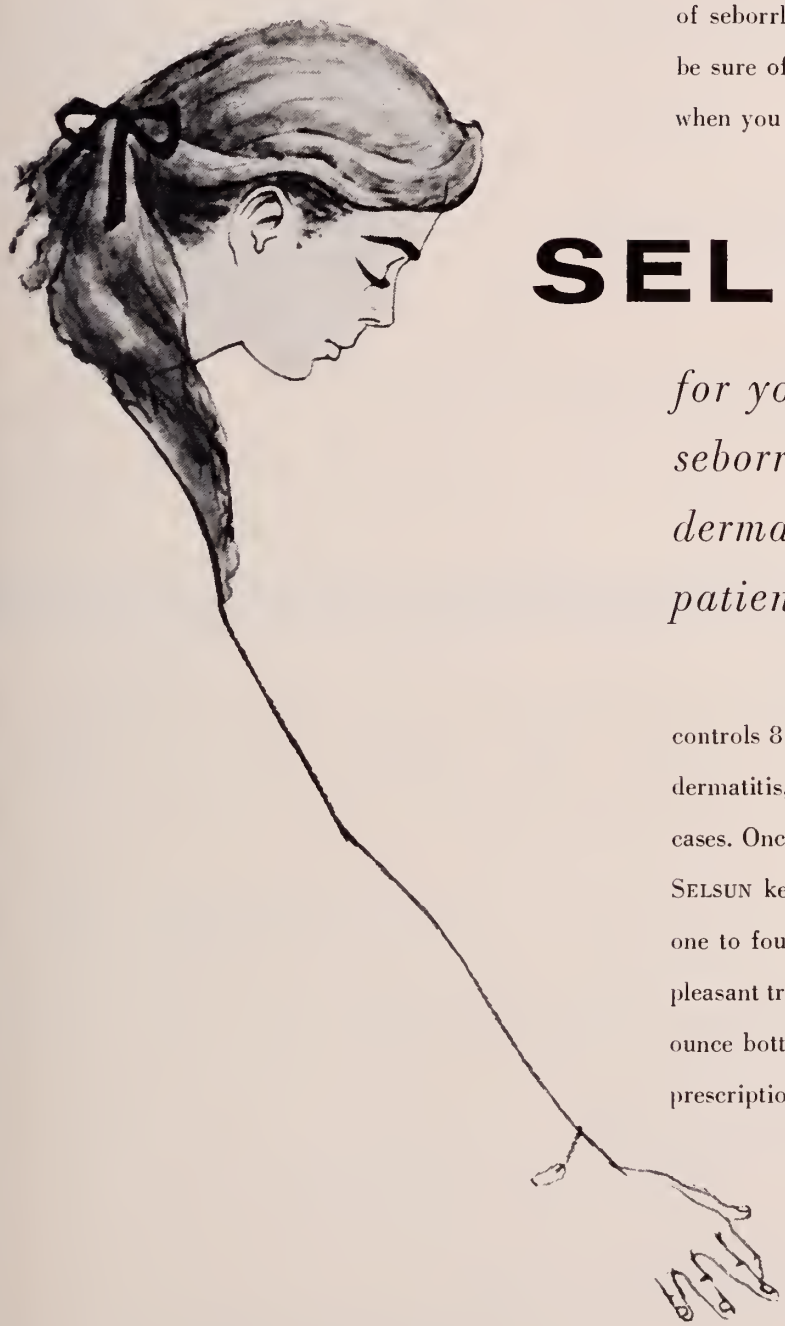

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of atomic weapons. *Dr. Harold Cook* of Milwaukee told of the planning of medical services in Milwaukee County, while *Dr. Joseph Mueller* of Wauwatosa discussed medical care of atomic casualties.

Walworth

On May 12, members of the Walworth County Medical Society and their wives met at the Colonial Hotel, Delavan, for a dinner meeting, at which *Dr. F. J. Millen,* Milwaukee neurologist, was the guest speaker. Doctor Millen is an associate professor at Marquette University School of Medicine.

Winnebago

The May meeting of the Winnebago County Medical Society was held at the Raulf Hotel, Oshkosh, on May 12. *Drs. Sherburne Morgan* and *Raymond Rice* of Milwaukee spoke on "Rheumatic Fever or Heart."

Wood

Dr. Robert D. Taylor, Marshfield, addressed members of the Wood County Medical Society at their meeting on April 21 at the Mead Hotel, Wisconsin Rapids. His subject was "Management of Hypertension."

Wisconsin Chapter, American College of Chest Physicians

The Wisconsin Chapter of the American College of Chest Physicians held its annual scientific session on May 1 at the Schroeder Hotel, Milwaukee. *Drs. R. P. Jahn* and *Armin R. Baier* of Milwaukee were program co-chairmen.

Speakers included Drs. Jay A. Myers of Minneapolis, professor of medicine and public health, University of Minnesota and its graduate schools; Arthur M. Olsen, Rochester, Minnesota, associate professor of medicine, Mayo Foundation, University of Minnesota; Albert H. Andrews, Jr., Chicago, assistant clinical professor of bronchoesophagology at the University of Illinois Medical School; *Abraham Melamed* and *Abraham Marck,* Milwaukee, members of the radiology department of Deaconess Hospital; *Chester M. Kurtz,* Madison, professor of clinical medicine, University of Wisconsin; and George L. Waldbott, Detroit, vice-president of the American College of Allergists.

Milwaukee Academy of Medicine

Members of the Milwaukee Academy of Medicine met on May 17 at the University Club, Milwaukee.

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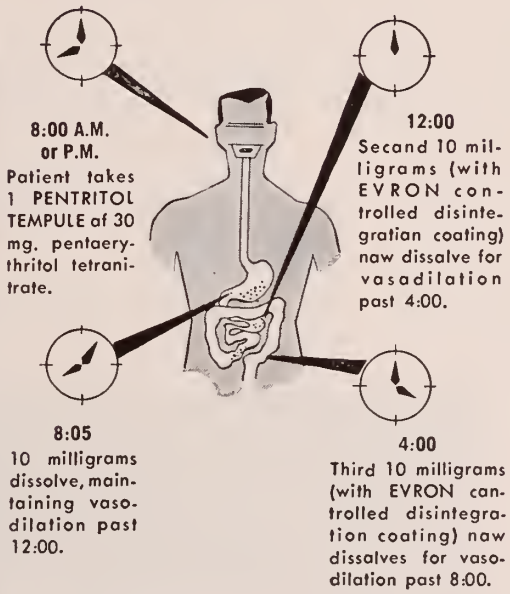

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1. Platz, N. Y. State Med. Jl. 52:16 (Aug. 15, 1952)
2. Russek and Assoc., 153:3 J.A.M.A. (Sept. 19, 1953)
3. Winsor and Humphreys, Angiology 3:1 (Feb. 1952)

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Guest speakers were *Dr. John Chamberlain*, Milwaukee, who spoke on "Plasma Fibrinogen in Myocardial Infarction," and Dr. Edwin Boyle, senior clinical investigator of the Laboratory of Metabolism, National Heart Institute, Bethesda, Maryland, who discussed "Cholesterolemia and Atherosclerosis."

Milwaukee Neuro-Psychiatric Society

On May 18 at the University Club, Milwaukee, members of the Milwaukee Neuro-Psychiatric Society heard an address by Dr. Henry A. Davidson, assistant superintendent, Overbrook Hospital, Cedar Grove, New Jersey. Doctor Davidson, who is a Diplomate of the American Board of Legal Medicine, discussed "Expert Testimony: The Psychiatrist as a Witness."

A business meeting and dinner preceded the scientific session.

Milwaukee Oto-Ophthalmic Society

A discussion of "Choanal Atresia" and films on "Simplified Dacryocystorhinostomy" and "Simplified Ptosis Operation" were the two features of the scientific program of the Milwaukee Oto-Ophthalmic Society at its meeting held at the Milwaukee University Club on April 26. *Dr. S. K. Wynn* of the Department of Maxillofacial Surgery of Milwaukee Children's Hospital gave the discussion, and the films were presented by Mr. Charles E. Iliff.

Wisconsin Society of Public Health Physicians

Dr. G. M. Shinners, District Health Officer in the Green Bay office, was elected president of the Wisconsin Society of Public Health Physicians when it held its meeting in Milwaukee during the time of the Annual Meeting of the State Medical Society. *Dr. Fred Welch*, City Health Officer, Janesville, was named president-elect; and *Dr. Milton Feig* of the State Board of Health, Madison, was elected delegate to the State Medical Society.

The society voted to hold its fall meeting at the Eagle Waters Resort at Eagle River, Wisconsin, on September 10 and 11.

Wisconsin State Urological Society

Dr. James J. King, Milwaukee, was elected the new president of the Wisconsin State Urological Society at its annual spring meeting held at the Park Hotel, Madison, on April 30. *Dr. Earl F. Cummings* of Oshkosh was named president-elect, and *Dr. Albert Graham*, Neenah, secretary-treasurer.

Wisconsin physicians who spoke at the meeting, and their topics, included:

Dr. J. F. McIntosh, Madison—"Bilateral Testicular Tumors and the Problem of Cryptorchidism"

Dr. R. J. Banker, Manitowoc—"The Cecum as a Substitute Bladder"

Dr. D. M. Appleton, Milwaukee—"Effect of Chloramphenicol on 100 Consecutive Transurethral Prostatic Resections"

Dr. G. W. Schwiebinger, Madison—"Management of the Ectopic Ureter"

Drs. J. D. and *S. J. Silbar*, Milwaukee—"Gastrointestinal Symptoms Produced by Renal Disease"

Dr. Albert Graham, Neenah—"Evaluation of Adequate Urinary Drainage"

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Dr. George Ewell, Madison—"Cushing's Syndrome—Follow-up Case Report"

Drs. J. B. Wear and J. M. Price, Madison—"Carcinoma of the Urinary Bladder, Clinical and Experimental Observations"

Dr. Knowlton E. Barber of the Urology Department at Northwestern University, Chicago, was the guest speaker and discussed "Management of Bladder Neck Lesions with Associated Pathology in Infants and Children."

At the banquet in the evening, Professor Roy J. Colbert, Director of the Bureau of Community Development at the University of Wisconsin, spoke on "Economic Trends in Wisconsin."

There is now an organized Section on Urology of the State Medical Society, and the State Urological Society will hold its 1956 annual spring meeting in conjunction with the convention of the State Society in Milwaukee.

Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology

Members of the EENT staff at the University of Wisconsin provided the program at the May 14–15 meeting of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology held in Madison.

Dr. Charles R. Taborsky discussed "Carcinoma of the Larynx," and *Dr. Frederic E. Mohs* lectured on "Chemosurgery as Applied to E.E.N.T." at the Saturday p.m. meeting held at University Hospitals. *Dr. Peter A. Duehr* presented clinicopathological cases. The evening meeting was held at the Madison Club, where *Dr. Frederick A. Davis* discussed "Wound Closure in Cataract Surgery."

Speakers at the May 15 morning meeting were *Dr. John V. Berger, Jr.*, who spoke on "Differential Diagnosis of Exophthalmos"; *Dr. Sidney O. Orth* and staff, whose topic was "Newer Advances in Anesthesia for E.E.N.T.; and *Dr. Maxine Bennett*, Mr. Vern Smith, and Mr. Kenneth Mangan, who lectured on "The Inarticulate Child." This session was held at University Hospitals.

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(1) Payne, R. W.; Shetlor, M. R.; Farr, C. H.; Hellbaum, A. A., and Ishmael, W. K.: J. Lab. & Clin. Med. 45:331, 1955. (2) Bunim, J. J.; Williams, R. R., and Black, R. L.: J. Chron. Dis. 1:168, 1955. (3) Holbrook, W. P.: M. Clin. North America 39:405, 1955.

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General Surgery, Two Weeks, October 3
Gallbladder Surgery, Ten Hours, June 27, October 24
Thoracic Surgery, One Week, October 3
Esophageal Surgery, One Week, October 10
Fractures & Traumatic Surgery, Two Weeks, June 20, October 17

GYNECOLOGY—Vaginal Approach to Pelvic Surgery, One Week, June 6
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MEDICINE—Two-Week Course, September 26
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Gastroscopy, One-Week Advanced Course, September 12
Gastroenterology, Two Weeks, October 24
Dermatology, Two Weeks, October 17

RADIOLOGY—Clinical Diagnostic Course, Two Weeks, by appointment
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PEDIATRICS—Neuromuscular Diseases, Two Weeks, June 20
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News Items and Personals

Dr. Arthur J. McCarey, immediate past president of the State Medical Society, was guest of honor at a dinner dance at the Hotel Northland, Green Bay, on Saturday, April 16. The Brown–Kewaunee–Door County Medical Society Auxiliary sponsored the affair. Left to right are Dr. John Boersma, Mrs. James McDermott, Mrs. Arthur McCarey, Mrs. Boersma, Dr. McCarey, Dr. McDermott, and Dr. James Nellen. *(Green Bay Press–Gazette Photo)*

Doctor McCarey Honored

Dr. Arthur J. McCarey, Green Bay, immediate past-president of the State Medical Society, was honored at a dinner dance held at the Hotel Northland in Green Bay on Saturday, April 16. One hundred and twenty doctors and their wives were present at this affair sponsored by the Brown–Kewaunee–Door County Medical Society Auxiliary.

Doctor McCarey has been practicing medicine in Green Bay since 1919 and has been active in both medical and civic affairs. He received his medical degree from Rush Medical College, Chicago, in 1912 and served his internship at the Hospital of St. Anthony de Padua in Chicago. Active in local and state medical societies, he has served as Councilor from the Sixth District, member of the House of Delegates, and former president of Brown–Kewaunee–Door County Medical Society. He is a Fellow of the American College of Surgeons, founder member of the Wisconsin Surgical Society, and Fellow of the American Medical Association.

Among those paying tribute to Doctor McCarey were Mrs. John Boersma, Green Bay, who is now the president of the Woman's Auxiliary to the State Medical Society; *Dr. James Nellen*, Green Bay, president of the Brown–Kewaunee–Door County Medical Society; *Dr. H. E. Kasten*, Beloit; *Dr. N. J. Wegmann*, Milwaukee; *Dr. John Bell*, Marinette; and *Dr. Robert Parkin*, Madison.

Out-of-town guests included physicians and their wives from Oconomowoc, Marinette, Sturgeon Bay, Seymour, Pulaski, Milwaukee, Oconto, Beloit, and Madison.

Doctor McCanna Accepts University Appointment

Dr. Phillip R. McCanna of Marinette has accepted an appointment in ophthalmology at the University of Illinois at Chicago. On May 31, he discontinued his practice in Marinette, where he had been associated with the Boren Clinic since February 1948.

He is a graduate of Marquette University School of Medicine and completed his internship and residency in Milwaukee. During 1946 and 1947, he served as a medical officer with the Army in Germany.

Oshkosh Area Physicians Visit Parke, Davis

A group of 24 physicians from the Oshkosh area visited Parke, Davis and Company, Detroit, on May

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Doctor Newcomb Honored

Dr. Kate Newcomb, Woodruff, was honored by the Junior Achievers of Southeastern Wisconsin on May 12, when she was cited as the outstanding career woman of Wisconsin.

Others included among the 10 Wisconsin people honored for achievements in various fields were Frank Lloyd Wright, Madison architect; Charlie Grimm, Milwaukee Braves manager; and Les Paul and Mary Ford, entertainers. The dinner at which these people were honored was held at the Milwaukee Arena.

Doctor Van Driest Enters Military Service

Sheboygan physician, *Dr. J. J. Van Driest,* reported for duty at Fort Sam Houston, Texas, on April 6. He had been at Sheboygan since 1952.

An orthopedic surgery specialist, he had practiced in Milwaukee as an assisting orthopedic surgeon and also worked in the Milwaukee Children's Hospital before coming to Sheboygan. He had taken three years of study in orthopedic surgery after serving his internship at Columbia Hospital, Milwaukee. He received his medical degree from the University of Wisconsin Medical School in 1946.

Physicians Honored by Fond du Lac Firm

When the Key Men's Club of the Fred Rueping Leather Company, Fond du Lac, held its 100th meeting on March 22, physicians who had served the company as members of the Reuping medical center were honored. *Dr. W. J. Waldschmidt* was the first physician to serve the center, and at present *Dr. David Smith* is in charge.

Fond du Lac physicians who have served the center and who were present at the banquet were *Drs. W. J. Waldschmidt, H. A. Devine, K. K. Borsack, W. J. Wojta, J. S. Huebner,* and *J. C. Swan.* Physicians unable to attend were *Drs. J. C. Devine, E. V. Smith,* Frank Yordy, *Robert Schroeder,* and *David Smith.*

Doctor Pelton Takes Over Cole Clinic

Dr. R. S. Pelton, Markesan, has taken over the Cole Clinic at Ripon, it was announced recently. Doctor Pelton has been at Markesan since 1946, when he returned from military service. He received his medical degree from the University School of Medicine at Louisville, Kentucky, in 1942.

Physicians Attend Reunions at Northwestern University

Dr. Frank Newell, Burlington, who has been practicing medicine for 55 years, went to Chicago on May 14 to participate in a reunion of his Northwestern University Medical School class of 1900.

Oshkosh physician, *Dr. H. H. Meusel,* was also at Northwestern University on May 14, attending a reunion of his class of 1905. Doctor Meusel was among the physicians honored recently by the State Medical Society at its Annual Meeting in Milwaukee, where he was made a member of the Society's 50 Year Club.

Doctor Evenson Opens Office in Marshfield

Dr. Roland Evenson, who formerly interned at St. Joseph's Hospital in Marshfield and took additional training at the Marshfield Clinic, has now returned to the city to open offices for the general practice of medicine. He has been at Cedarburg for the last eight months. A graduate of Marquette University School of Medicine, Doctor Evenson received his medical degree in 1952.

Doctor Boren Addresses Safety Conference

Dr. C. H. Boren, senior member of the Boren Clinic, Marinette, was one of four speakers who addressed the regional Fox River Valley and Lake Shore Safety Conference in Marinette on May 13. This conference drew delegates from 17 northeastern Wisconsin counties and the Upper Peninsula. His topic was "A Prescription for Safe Living." Doctor Boren is an industrial consultant for several local Marinette firms.

Doctor Mauthe Joins Staff of Berlin Hospital

Dr. Howard Mauthe, Fond du Lac radiologist, has joined the staff of the Berlin Memorial Hospital. He will be at the hospital on Wednesday afternoons

Since 1951, Doctor Mauthe has been radiologist at St. Agnes Hospital, Fond du Lac. He serves Ripon Hospital in a similar capacity.

He received his radiologic training in Milwaukee, serving as resident radiologist at the veterans hospital at Wood and also at Milwaukee Hospital and Milwaukee Children's Hospital. He is certified by the American Board of Radiology, the North American Radiological Society, and the American Hospital Association.

Sheboygan Physicians Attend ACS Meeting

Drs. J. R. Hoon and *F. G. Hidde* recently attended a sectional meeting of the American College of Surgeons. The meeting was held in Cleveland, Ohio.

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

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Brown, H. W.: J. Pediat. 45:419, 1954.

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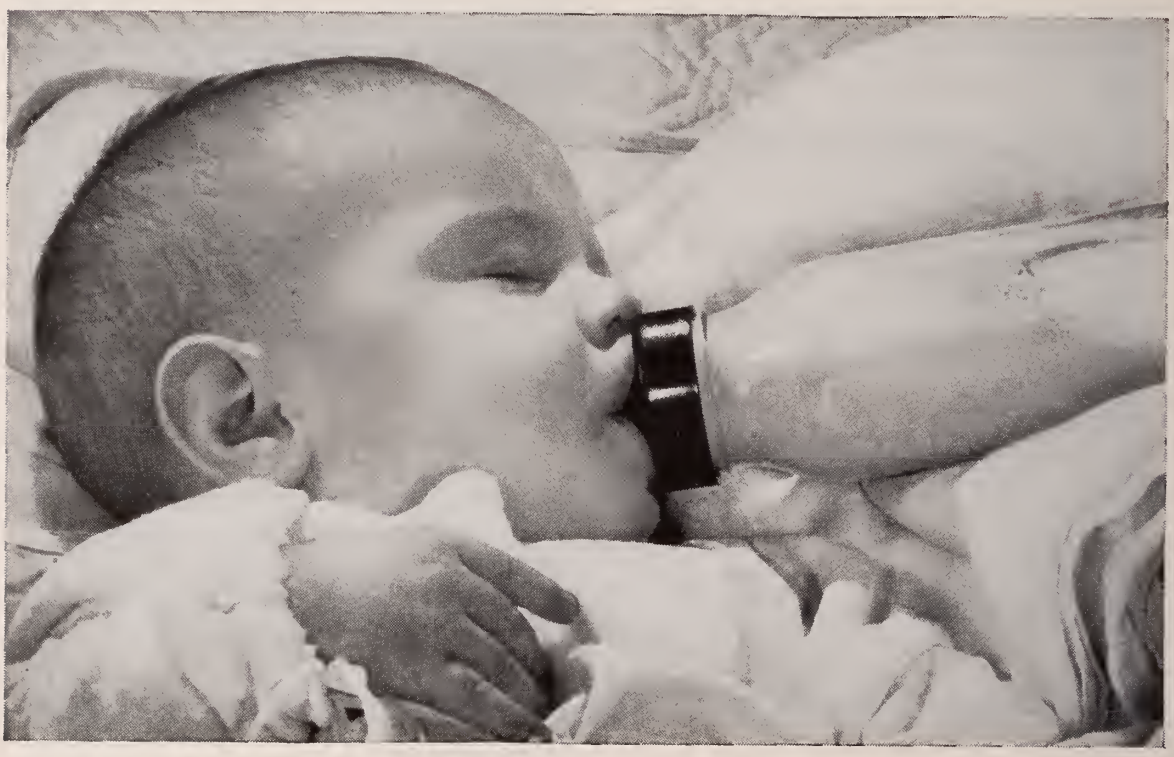

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Doctor Edwards Attends European Meeting

Dr. and Mrs. *C. W. Edwards*, Richland Center, attended the meeting of the International Surgical Congress in Geneva, Switzerland, on May 23–25. While in Europe, they visited France, Italy, Switzerland, Austria, Germany, Belgium, Holland, and England. They flew back to Atlantic City in time to attend the A.M.A. convention starting June 6.

Dr. Hugo Bachhuber Resumes Practice in Athens

Dr. Hugo Bachhuber has returned to Athens after two years in the Army. He will be associated with his brother, *Dr. G. J. Bachhuber*. While in service, he spent most of his time in Texas and Missouri and at Camp McCoy, Wisconsin. He was discharged with the rank of lieutenant colonel.

Doctor Colgan Speaks to Medical and Dental Assistants

Dr. Harry Colgan of Winnebago State Hospital was guest speaker at a dinner meeting of the Fond du Lac County Medical and Dental Assistants group on April 21 at the Fond du Lac Town and Country Club. He talked about the facts and figures of mental health.

Doctor Merrill Elected County Physician

Dr. W. G. Merrill, Ashland, was recently elected Ashland County physician. His appointment was effective as of May 1.

Kaukauna Doctor Cited for Community Service

Dr. G. J. Flanagan of Kaukauna recently received a commendation voted by the common council of the city. He was cited for his service as health officer and for his many services to the community as a physician and citizen.

Doctor Kerscher in Europe

Dr. E. J. Kerscher, Casco, left in late May for a vacation trip to Europe. Highlights of the trip, which will include visits to France, Belgium, Holland, Switzerland, Austria, Italy, and England, will include a visit to a military cemetery in France where Doctor Kerscher's brother is buried and visits to the birthplace of Doctor Kerscher's parents in Germany.

Dr. H. G. Pudleiner, Algoma, is handling Doctor Kerscher's practice during his trip.

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Doctor Sivertson New Physician in La Crosse

On April 1, *Dr. Sigurd E. Sivertson* assumed his duties as a member of the staffs of the Gundersen Clinic and the La Crosse Lutheran Hospital.

Specializing in internal medicine, Doctor Sivertson has just completed a three-year fellowship in that field at the Mayo Clinic. He received his M. D. degree from the University of Wisconsin in 1947 and interned at St. Luke's Hospital, Duluth. Before entering military service in 1949, he had had one year of residency training at La Crosse Lutheran Hospital. He served with the Army Medical Corps for two years, being discharged with the rank of captain.

THIRD AND TWELFTH DISTRICTS NEWS

Monroe Physician Speaks at District Nurses Association Meeting

Dr. D. W. Springer, Monroe, was the guest speaker at the meeting of the Second District of the Wisconsin State Nurses Association held at the Monroe Country Club on May 10. He spoke on surgery and was assisted by *Dr. R. G. Zach*, Monroe, who showed slides.

Doctor Tenney Speaks at Mental Health Conference

Dr. H. Kent Tenney, Madison pediatrician, was the main speaker for the morning session of an interprofessional mental health conference held at the Lincoln School, Appleton, on April 30.

Speaking on "Emotional Problems in Children," Doctor Tenney stated that mental health is more than just the absence of mental illness and that mental health education must begin as soon as an infant is born. Every child wants the approval of parents but even sternness is better than lack of attention. Guidance is better than training and implies understanding where training does not. The basis for developing good emotional health in children, stated Doctor Tenney, is to understand what they are thinking as well as what they are doing.

Aimed at developing cooperation and coordination in community guidance work, the conference was sponsored by the Outagamie County Mental Health Association in cooperation with the Wisconsin Mental Health Association.

Doctor Brenner Moves to Middleton

Dr. J. J. Brenner has joined the Busch Clinic in Middleton. He is a graduate of Marquette University School of Medicine and interned at St. Lawrence

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Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Earl H. Ninow, M. D.
Paul J. Lawler, M. D.

Hospital, Lansing, Michigan. He was in service for four years during World War II and practiced at Adams, Wisconsin, before moving to Middleton.

Dr. Arnold Jackson Attends ICS Meeting in Switzerland

From May 22 to 26, *Dr.* and Mrs. *Arnold Jackson*, Madison, attended the world meeting of the International College of Surgeons in Geneva, Switzerland. Doctor Jackson is president of the United States Section of ICS and spoke at the conference.

Following the meeting, they planned to drive through Italy, Austria, and Germany with a group of American doctors, seeing Rome, Florence, Genoa, Innsbruck, and the Rhine River Valley en route. They also intended to spend a few days in London before their return about June 17.

On his way to Europe, Doctor Jackson spoke at the Jersey City Medical Center, Jersey City, New Jersey, on May 14.

Dr. James Moore Opens Office in Madison

Returning to Madison after two years in the Air Force, *Dr. James N. Moore* has opened an office for the general practice of medicine, surgery, and obstetrics. He practiced in Madison for a year before going into service.

While in service, he was stationed at the Youngstown, Ohio, Air Force Base, where he was base surgeon. He had the rank of captain at the time of his discharge.

Doctor Moore received his medical degree from the University of Cincinnati.

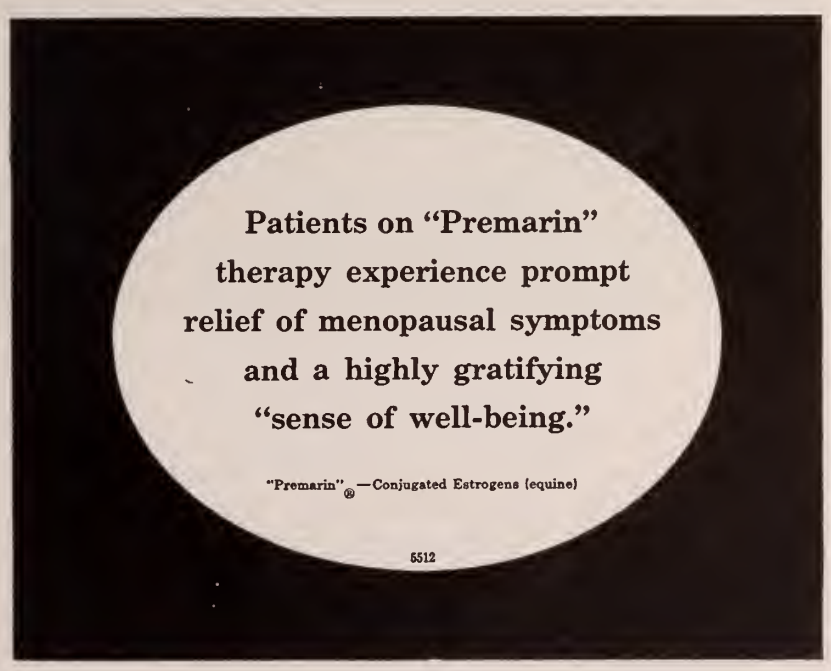
Doctor Engstrom Elected to Membership in Clinical Investigation Society

Dr. W. W. Engstrom, associate professor of medicine at Marquette University School of Medicine, was recently elected to membership in the American Society for Clinical Investigation.

Membership is restricted to a limited number of men under 45 years of age who are engaged chiefly in medical teaching and research. A specialist in general internal medicine, Doctor Engstrom has done major research on problems of steroid hormones and the thyroid. He is the first Milwaukee physician chosen for membership in this society.

Doctor Margoles Cited by Dental Group

Dr. Frank C. Margoles, Milwaukee, is the first physician and the third person to be elected an honorary member of Omicron Kappa Upsilon, national honorary dental society at Marquette University. A member of the Marquette dental faculty for 25 years, Doctor Margoles was chosen for his service as a teacher of dental history and bacteriology.



Milwaukee Physicians ACS Fellows

Drs. L. L. Garner, J. W. Sargent, and *J. R. Stone,* all of Milwaukee, were inducted as Fellows of the American College of Surgeons at the last surgical congress held by the College. This meeting was held on November 19, 1954, at Atlantic City.

Doctor Hardgrove Speaks to Medical Fraternity

Dr. Maurice Hardgrove, Milwaukee, was the guest speaker at the annual initiation program of the Nu Sigma Nu medical fraternity of the University of Wisconsin. The meeting was held at the Blackhawk Country Club, Madison, on the evening of April 30. Doctor Hardgrove discussed "The Imaginary Invalid." Dr. O. A. Mortensen, acting dean of the University of Wisconsin Medical School, was honored guest at the meeting and introduced Doctor Hardgrove, who is a charter member of the University of Wisconsin chapter of Nu Sigma Nu.

In the afternoon, formal initiation for new members had been held at the Old Stamm House, Middleton.

MARRIAGES

Dr. P. P. Bassewitz, Sheboygan, to Miss Barbara Ruth Glaser, New York City.

Dr. Grant Stone, Berlin, to Mrs. Edna Van Horne, Berlin, March 23.

SOCIETY RECORDS

New Members

L. V. Kempton, 642½ Pine Street, Burlington.

J. H. Noble,* 912 Harrison Street, Black River Falls.

C. L. Meyers,** 103 West College Avenue, Appleton.

J. F. Bigalow, Merrill.

J. W. Erchul, St. Clare Hospital, Monroe.

C. E. Shearer, Columbus.

J. L. Algiers, 110 North Main Street, Hartford.

Benjamin Schuster, 1300 University Avenue, Madison.

T. E. Nesbitt, 208 East Wisconsin Avenue, Milwaukee.

J. E. Geigler, 545 North 91st Street, Milwaukee.

R. F. Barta, 2303 North 94th Street, Milwaukee.

A. A. Charbonneau,* 320 North Washington Street, Green Bay.

H. S. Atkinson,* 109 South Madison Street, Green Bay.

L. W. Gregory,* Box 348, Sarasota, Florida.

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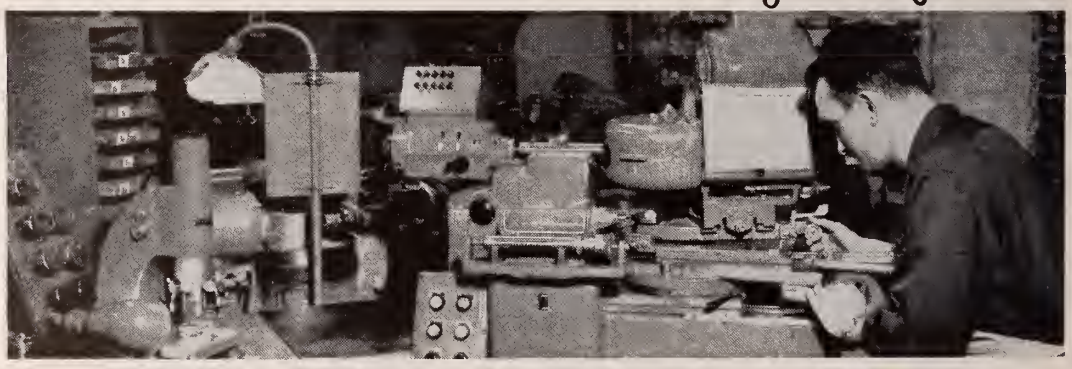

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Changes of Address

W. J. Bleckwenn, Winter Haven, Florida, to 3441 Crestwood Drive, Madison.

B. J. Longley, Fort Knox, Kentucky, to Veterans Administration Hospital, Madison.

H. R. Duffy, El Toro, California, to 3107 North Hackett Avenue, Milwaukee.

W. H. Thiede, Great Lakes, Illinois, to 1802 North 57th Street, Milwaukee.

K. J. Stollenwerk, Fort Hood, Texas, to 3759 South Austin Street, Milwaukee.

Kinge Hara, Seattle, Washington, to 1729 South 11th Street, Milwaukee.

C. H. Mahaffey, Barron, to 1910 Cummings Avenue, Superior.

W. H. Houlton, Cumberland, to 212 Emerald Street, S. E., Minneapolis, Minnesota.

R. K. Salter,** El Paso, Texas, to 6440 North Pershing Avenue, Stockton, California.

H. R. Foerster, Jr.,** Milwaukee, to U. S. Navy Recruiting Office, Detroit, Michigan.

J. P. Pauly,** La Crosse, to 64-30H, 186th Lane, Fresh Meadows 65, New York.

J. N. Moore, Youngstown, Ohio, to 3414 Monroe Street, Madison.

H. M. Bachhuber, Neosho, Missouri, to Athens.

J. J. Coheen, Fort Lewis, Washington, to Apartment 4, 4525 North Woodruff Avenue, Milwaukee.

D. J. Albrecht, Edward Air Force Base, California, to 4729 West Fillmore Drive, Milwaukee.

R. R. Liebenow, % Postmaster, San Francisco, California, to Lake Mills.

G. P. Nichols,** Denver, Colorado, to 7010 South Chicago Avenue, Minneapolis, Minnesota.

T. J. Budnick, Waterford, to 108 South Church, East Troy.

J. J. Gordon,** New Richmond, to School of Aviation Medicine, Naval Air Station, Pensacola, Florida.

W. H. Dornette, Madison, to Division of Anesthesiology, U.C.L.A. Medical Center, Los Angeles 24, California.

E. M. Parkin, River Forest, Illinois, to 4608 North Wilson Drive, Milwaukee.

R. G. Evenson, Cedarburg, to 251 South Central Avenue, Marshfield.

R. F. Schoen,** % Postmaster, New York, to U. S. Army Infirmary, Fort Sheridan, Illinois.

C. M. Strand, Chicago, Illinois, to Westby.

J. S. Altman, Downey, Illinois, to 2407 Buchanan Road, Kenosha.

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DEATHS

Dr. Robert R. Jacks, Menard, Illinois, passed away on February 26 at a St. Louis, Missouri, hospital at the age of 77 years.

Born on July 22, 1877, in New Orleans, Louisiana, he obtained his medical education at the University of Illinois, graduating in 1905. He served in the Hospital Corps of the United States Army from 1905 to 1914 and was in private practice in Illinois from 1914 to 1917 and from 1920 to 1940. He served with the Medical Corps on active duty from August, 1917, to July, 1920.

Doctor Jacks did general practice in Park County, Wyoming, for a short period in 1940 and then moved to Oklahoma, where he was a contract surgeon for a year and a half. In January 1942 he joined the Rock Springs Medical Group of Rock Springs and Superior, Wyoming; and in April 1943 he joined the medical department of the J. I. Case Company at Racine, Wisconsin. He remained there until April 1948, when he entered general practice in Racine. In June 1950 he became prison physician at the Illinois State Penitentiary at Menard, Illinois.

Doctor Jacks was a member of the Juneau County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, in St. Louis, Missouri.

Dr. Charles Arthur Pardee, former Appleton physician, died on April 22 at his home in Fort Myers, Florida, where he had resided since his retirement in November 1953. He was 59 years of age.

Born on August 13, 1895, in Appleton, he received his medical degree from Northwestern University Medical School, Chicago, in 1926 and interned at Wesley Memorial Hospital, Chicago. During World War I, he served with the Navy. He practiced at Appleton from 1930 until his retirement in 1953.

Doctor Pardee was a former member of the Outagamie County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Survivors include his widow, Doris, and two sons, Arthur and Emil, both of Berkeley, California.

Dr. George Vincent Lynch, Oshkosh physician since 1922, died at Miami, Florida, on April 28 while on vacation. He was 67 years of age.

Doctor Lynch was born on November 18, 1887, at Winona, Minnesota. He attended medical school at the University of Minnesota at Minneapolis, graduating in 1915. He interned at the City and County Hospital, St. Paul, now the Ancker Hospital. He had a year's residency at Ancker Hospital and three years' postgraduate work in surgery at the Mayo Clinic and began practice at Oshkosh in 1922.

Doctor Lynch was chief of surgery at Mercy Hospital, Oshkosh. He was a Fellow of the American College of Surgeons and a member of the Wisconsin Surgical Society. He was a member of the Winnebago County Medical Society, of which he had served as president; the State Medical Society of Wisconsin; and the American Medical Association.

Surviving are his widow, Hazel; three daughters, Mrs. Gerald J. Dowling, Lincoln, Nebraska, and Mrs.

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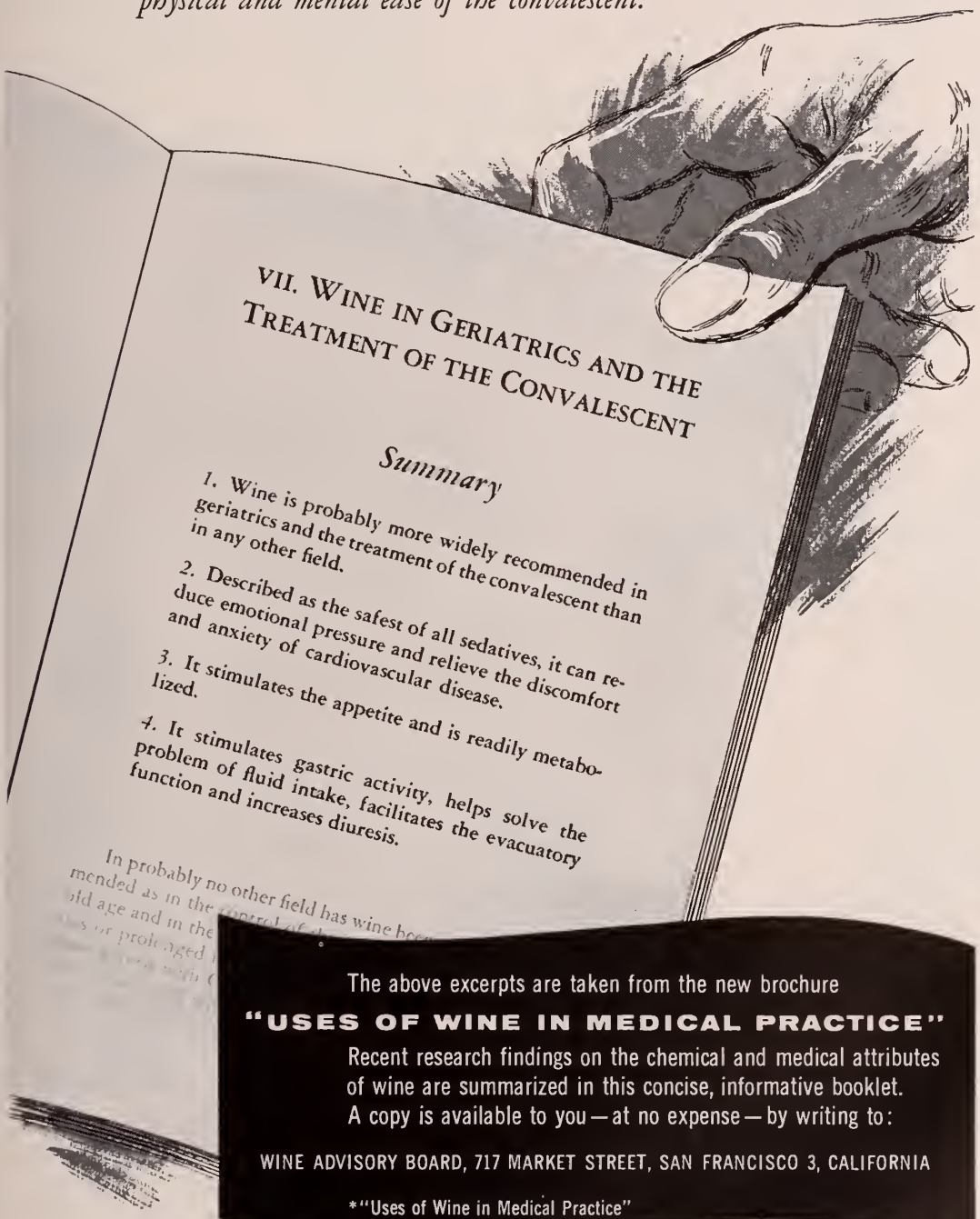

Richard O'Connor and Miss Patricia Lynch of Oshkosh; two sons, William R. and George V., Jr., both of St. Paul; two brothers, William of Sedley, Saskatchewan, Canada, and Thomas of Barberton, Ohio.

Dr. Karl J. Klocker, who practiced at Burlington since August 1953, was killed April 29 when pinned beneath a tractor on his farm near Silver Lake, Wisconsin. He was 48 years of age.

Born in Chicago on August 12, 1906, he received his medical degree from Rush Medical College, Chicago, in 1933. He interned at Mercy Hospital, Chicago, and did postgraduate work in blood dyscrasia at Rush for another year. He began his practice in Chicago in 1935 and moved to Burlington in August 1953.

During World War II, Doctor Klocker served in the Army Air Transport command. He was an associate member of the surgical staff at Mercy Hospital, Chicago, and had been a clinical instructor of surgery at Loyola University. He was a member of the Racine County Medical Society, the State Medical Society and the American Medical Association.

Survivors include his widow, Bernice; five daughters, Patricia, Anna, Barbara, Kathleen, and Mrs. James May; his mother, Mrs. Anna Klocker, Chicago; and three sisters, Mrs. William Davern, Mrs. Harry Wisdom, and Mrs. Robert Hoobler.

Dr. Philip Hanuch Perlson, 56-year-old Milwaukee physician, died at his home on April 29.

He was born on September 7, 1898, in Russia and was brought to Milwaukee at the age of 9 years.

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He received his medical education at Marquette University School of Medicine, Milwaukee, and St. Louis University School of Medicine, St. Louis, graduating from the latter in 1924. He interned at Mt. Sinai Hospital, Milwaukee, and then started his practice in Milwaukee. Doctor Perlson was a former assistant chief of staff at Mt. Sinai Hospital and a former member of the hospital's executive committee. He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow, Goldie; a daughter, Mrs. Hinda Burchman; a son Dr. Samuel G. Perlson; his mother, Mrs. Fanny Perlson, all of Milwaukee; a sister, Mrs. Rose Adashek, Waukesha; and three brothers, Samuel B., Milwaukee, Dr. Joseph of San Bernardino, California, and Max, Altadena, California.

Dr. Patrick Francis Dockry, Green Bay proctologist, died on May 10 at a Green Bay hospital. He was 49 years of age.

He was born on January 1, 1906, at Green Bay and received his medical education at Marquette University School of Medicine, graduating in 1933. He interned at Milwaukee County General Hospital and completed a two-year residency at that hospital.

Doctor Dockry began his practice in general medicine and surgery at Green Bay in 1935. In 1945 he took postgraduate work at the University of Pennsylvania, after which he returned to Green Bay to specialize in proctology.

He was a member of the American Proctologic Society and was on the active staff of St. Mary's, St. Vincent's, and Bellin Memorial hospitals, Green Bay. He had served as an alternate delegate from his county medical society to the House of Delegates of the State Medical Society.

Doctor Dockry was a member of the Brown–Kewaunee–Door County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Genevieve; a daughter, Mary Ann; three sons, Patrick, Michael, and Dennis; a brother, John, Green Bay; and three sisters, Miss Mary, Green Bay, and Mrs. Hugo Murray and Mrs. Thomas A. Delaney, Milwaukee.

Dr. Harry E. Breckenridge, who was located at the Grand Army Home for Veterans at King prior to his retirement in 1953, passed away at the Odd Fellows Home, Green Bay, on May 13 at the age of 87 years.

Born on February 11, 1868, at Mercer, Pennsylvania, he received his medical degree from Baltimore University School of Medicine, Baltimore, Maryland, in 1892. He first practiced at Racine,

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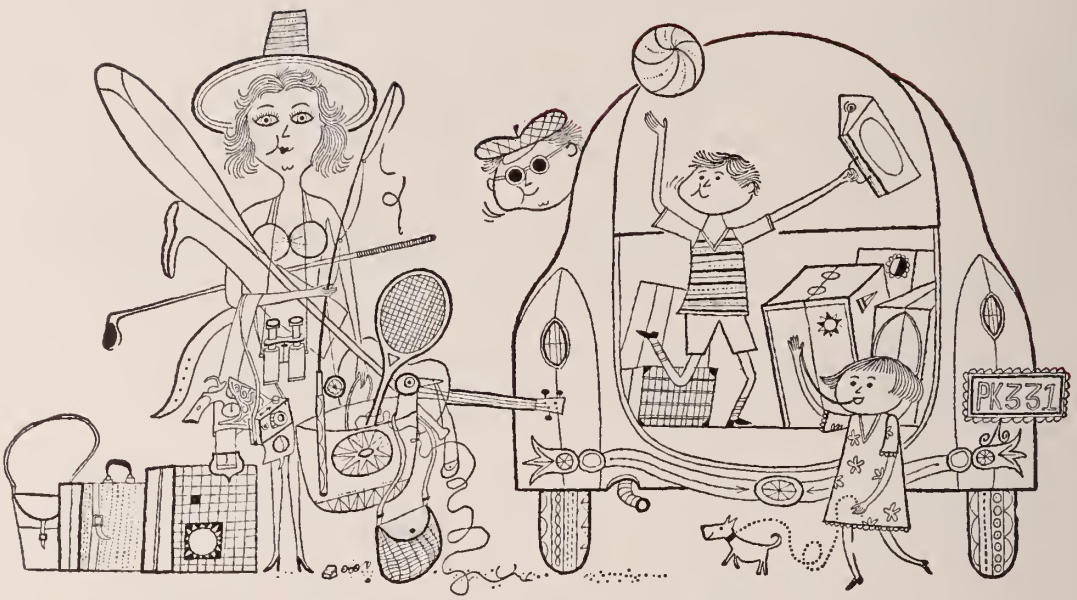

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moving to the Grand Army Home in 1917. His interest was the field of eye, ear, nose, and throat.

He was a member of the Racine County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Doctor Breckenridge is survived by one son, Edmund, of Theodore, Alabama. His wife preceded him in death in 1953.

Dr. Frank George Hiram Maloney, Madison surgeon, died on May 15 in a Madison hospital at the age of 55 years.

He was born on September 11, 1899, in Ontario, Canada, and was graduated from the University of Toronto Faculty of Medicine, Toronto, Canada, in 1924. He interned at Lucas County Hospital, Toledo, Ohio, and held a Fellowship at the Mayo Clinic for three years, from 1925 to 1928.

In 1929 Doctor Maloney started practice at Ironwood, Michigan, where he remained until 1943. Then he joined the staff of the Quisling Clinic in Madison, where he practiced until his death. He was a partner in the Quisling Clinic and was on the staff of Madison General Hospital.

Doctor Maloney was a Fellow of the American College of Surgeons and a member of the International College of Surgeons, the Residents and Ex-Residents Society of the Mayo Clinic, and the Wisconsin Surgical Association. He was a past president of the Upper Michigan Medical Society.

He held membership in the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, Josephine; a daughter, Mrs. William Hart, of Saratoga, Wyoming; two sons, Frank and John at home; his mother, Mrs. G. A. Maloney, Toronto, Canada; two sisters, Mrs. George Moore, Jeffersonville, Indiana, and Mrs. Harry Evans of Toronto; and a brother, the Rev. A. A. Maloney, Bedford, Indiana.

Dr. Fred Arthur Soles, Platteville physician, died at a Marshfield hospital on May 18 at the age of 80 years.

Doctor Soles was born July 16, 1874, at Fond du Lac. He graduated from Hahnemann Medical College, Chicago, in 1903 and practiced at Walla Walla, Washington, and Spencer, Wisconsin, prior to locating at Platteville. He retired from active practice in 1953.

Doctor Soles had taken some additional training in eye, ear, nose, and throat work at the Chicago Infirmary.

He was a member of the Grant County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow; a daughter, Mrs. Kenneth Graves, Spencer; and a son, James, Platteville.

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Wisconsin Medical Journal
704 East Gorham Street
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Gentlemen:

In your March issue you have an editorial titled "Capsule Magazines," which appears to me rather confusing in view of some of the facts relating to recent successes in the publishing business. While I am prone to agree with your concept that there are more medical journals published than can possibly be read—or even scanned—by the busy physician, the success of the newer journals is, in fact, based on physician readership and their resultant value to the advertisers.

But rather than attempt to defend the "medical digest" or abstract journals at large, I'd rather confine my remarks to our publication "Pfizer Spectrum," run as a weekly insert in *The Journal of the American Medical Association.* From its original concept, we have felt that the editorial material contained in "Spectrum" must serve a purpose in providing the busy physician with service material not readily obtainable from other sources. It is far from being a part of our concept to usurp the basic function of those medical journals devoted basically to clinical medicine, and in no case do we attempt to duplicate material published as a clinical report. This material, we feel, is the province of medical journals such as yours; and we have not, since the inception of "Spectrum" in 1952, published any original clinical papers, nor do we consider our pieces to be abstracts of any individual physician's report.

Rather, we feel the pace of medicine is such today that the busy practitioner often welcomes the opportunity to see, in their proper perspective, the newer medical findings in relation to earlier reported work and results. Thus, we review in terse, authentic fashion, medical problems which we feel will be helpful to the physician reader who seems to find less and less time with the published literature. With liberal use of pictures, good design and layout, we sincerely feel that "Spectrum" offers a means of keeping abreast with developments. And—while we're at it—a word or two on "style" in the field of medical literature. I feel sure you'll agree with me that the best clinicians are often not the best writers, which often results in tedious clinical papers being published in many of our better medical journals. In developing "Spectrum," we have been careful to staff our group with medical editors and writers who are not only successful physicians but also outstandingly facile at expressing themselves.

In the final analysis the success of every publication—in every field—is based on the reader's opinion of it, his desire to read it, and his renewal of his subscription. Although we have published "Spectrum" less than three years, our correspondence from a number of sources indicates a growing interest in our publication, and an appreciation from many segments of the profession for the job we are attempting to do.

We do appreciate your thoughts on the subject, however, as we feel continually concerned with the problems of communication with the medical profession.

Cordially yours,
/s/ E. W. WHITNEY
Advertising Director

E. W. Whitney, Advertising Director
Chas. Pfizer & Company, Inc.
Flushing Avenue
Brooklyn 6, New York

Dear Mr. Whitney:

Thank you for your comments on our editorial in the recent issue of *The Wisconsin Medical Journal.*

As the advertising director of your company, we can well understand your concern with our editorial and appreciate your letter. However, we have had only one other letter which agrees with your criticisms and which is being published along with yours.

Sincerely yours,
/s/ JAMES M. SULLIVAN, M. D.
Editorial Director

THE MONROE CLINIC
Monroe, Wisconsin

Editor
The Wisconsin Medical Journal
Madison, Wisconsin

Dear Sir:

The editorial on page 36 of the March 1955 *Wisconsin Medical Journal* I think is very untimely, and the criticisms that are made in it are entirely unjustified.

I feel that the capsule magazines that you refer to serve a very worth-while purpose in abstracting articles from many journals and making them available to us. I find that many times there will be articles that are brought to my attention in this manner so that I can go and look up the original material which I would have otherwise missed. If for no other purpose, this, as far as I am concerned, would justify their existence; and I am quite sure that the publishers of these "Capsule Magazines" realize this usefulness of their work.

The AMA *is not open* to criticism for the advertising to which you refer. Many times I find the material published in this twelve-page advertisement of Pfizer will contain more information that is of direct interest to me than all of the rest of the journal combined.

Perhaps your editorial can be excused on the basis that you had had a bad day and were up most of the night before it was written, but I know of no other justification for the criticism. I hope that many other people will write to you about your editorial.

Sincerely yours,
/s/ PAUL W. SNOWDEN, M. D.
Department of Radiology

Ed. Note: Your editor did not have a bad day and is still of the same opinion.

R. W. SCHMITT, M. D.
Northwoods Hospital
Phelps–Vilas County, Wisconsin

Editor
Wisconsin Medical Journal
704 East Gorham Street
Madison 3, Wisconsin
Dear Editor:

Allow me to object strenuously to the enclosed editorial *(p. 24, April 1955 Wisconsin Medical Journal)* and to express the hope that we have no similar ones in our editions to come.

I object to the tone of the article and to the insinuation that we are or should be embattled against our President. I question that it expresses the opinion of our editorial staff or our organization.

It does not belong on the editorial page in my opinion—perhaps not in the magazine at all. What do you think?

Yours truly,
/s/ R. W. SCHMITT, M. D.

Dear Doctor Schmitt:

Thank you for your comments on the editorial in the April 1955 issue of *The Wisconsin Medical Journal.*

This, of course, was a reprint from *The Journal of the Arkansas Medical Society* and it may not be the complete editorial thoughts of our own Journal. Nevertheless, it has the sanction of your editorial director. Because the President is criticized on a few moves he has made does not mean that we are not backing the President in the majority of the things he has done but, this being a democracy, we must insist that when we think some of his legislation is ill-advised we may say so.

Sincerely,
/s/ JAMES M. SULLIVAN, M. D.
Editorial Director

Office of
A. W. Bouffard, Chairman
Crippled Children's Commission
200 S. Broadway
Green Bay, Wisconsin

Mr. C. H. Crownhart, Executive Secretary
Wisconsin Medical Association
704 East Gorham Street
Madison, Wisconsin

Dear Mr. Crownhart:

On behalf of the Wisconsin Elks Association, through its Crippled Children's Commission, we wish to express our sincere appreciation to the members of the medical profession of Wisconsin for their generous and understanding cooperation in providing assistance to those crippled children who are referred to our local lodges for medical services.

The generous attitude of the doctors cooperating with us makes it possible for the Elks to assist those in need.

May we have your continued cooperation.

Very sincerely yours,
/s/ A. W. BOUFFARD, *Chairman*
Crippled Children's Commission
Wisconsin Elks Association

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PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

WANTED: General practitioner for rural community. Large practice, grossing $20,000 per year. Large, modern, fully equipped office with laboratory, including G. E. x-ray with fluoroscopy, new G. E. diathermy and E. C. G. equipment. Available on extremely liberal terms. Previous physician now in medical research. Young dentist and pharmacist in same building. Address replies to Mr. Edward Kraemer, Plain, Wis.

WANTED: Physician to take over practice of owner who expects to enter military service in near future. Community of 2,300 with hospital facilities nearby. Equipment may be purchased. Possibility of association following service. Address replies to Box 596 in care of the Journal.

WANTED: New or used ether suction anesthetic machine, cabinet model, erosion proof. Phone or write M. Margoles, M. D., 1971 W. Capitol Drive, Milwaukee, Wis.

PHYSICIANS WANTED: The Mendota State Hospital has temporary staff positions available for young doctors awaiting military or residency assignments. Contact Dr. A. Soucek, Assistant Superintendent, Mendota State Hospital, Madison 4, Wis.

PHYSICIAN–SURGEON WANTED for industrial community serving 3,000 people within 20-mile area. Will lease attractive doctor's residence and fully equipped first-aid hospital for private practice. Estimated net income of $10,000 for first year, and practice should increase each year thereafter. Available for immediate occupancy. Phone or write Goodman Lumber Company, Goodman, Wis.

LOCATION OPPORTUNITY: New brick home–office building in prosperous community within 25 miles of Madison. New hospital to be constructed. An unusual opportunity for general practitioner. Address replies to Box 588 in care of the Journal.

FOR SALE: Several Jones motor basal units in perfect condition, guaranteed to be accurate. Short-wave unit, FCC approved. Medcotronic muscle stimulator, only slightly used, $75. Treatment table, perfect condition, $50. Electrocardiograph in good condition. Assorted cassettes, film filing cabinets, new and used. Address replies to C. C. Remington Company, 1204 West Walnut Street, Milwaukee 5. Telephone, Locust 2–8118.

FOR SALE: Combination house, office, and practice. Excellent location in north central Wisconsin, in territory including several towns and villages without a doctor. Practice established over 20 years. Modern home and office; office completely furnished. Civic groups will give support. Owner selling because of age and poor health. Address replies to Box 587 in care of the Journal.

FOR SALE: Milwaukee general practice, established for 30 years, grossing $20,000. Available June 1 for price of equipment. Stipend guaranteed. Owner is specializing. Address replies to Box 593 in care of the Journal.

FOR SALE: 60 MA x-ray complete with table and equipment; Hanovia ultraviolet lamp; 5 horsepower General Electric air conditioner; mahogany desk and chair; steel desk; and waiting room furniture. All in good condition. Write Dr. E. M. Kay, 3323 N. Green Bay Ave., Milwaukee 12, Wis.

FOR RENT: Office space for physicians in modern, air-conditioned, three-story professional building with elevator. Contact R. H. Lehner, M. D., 312 Seventh St., Racine, Wis.

FOR SALE: Property of recently deceased Wisconsin physician and surgeon in desirable, prosperous rural community. Modern hospital facilities available. Property includes brick home, office facilities, and two-car brick garage. Lot is approximately 80′ by 180′. Office equipment, instruments, etc., if desired. Financing available. Address replies to Box 597 in care of the Journal.

FOR RENT: Modern private medical office. Six rooms, on ground floor, adjoining dental office. In Beaver Dam, Wis. Address replies to Box 591 in care of the Journal.

FOR SALE: Medical equipment in excellent condition. Purchased new in November 1949 and used for only two years. Included are x-ray, electrocardiogram, microtherm, diathermy, B.M.R., and multiple accessory supplies. Address replies to Box 598 in care of the Journal.

OFFICE FOR RENT: Well-established, well-equipped general practitioner's office available for immediate occupancy. In east-central Wisconsin location with new community hospital and a drawing territory of ten to fifteen thousand. Address replies to Box 595 in care of the Journal.

FOR SALE: Abrahamson Sedimentation Tube outfit with base and assembly. Address replies to Box 600 in care of the Journal.

WANTED: Resident physician, full or part time. Call or write Medical Director, Capitol Hospital, 1971 W. Capitol Drive, Milwaukee, Wis., Hi. 4–1400.

FOR SALE BY WIDOW OF PHYSICIAN: General practice in city of 4,000 in southeastern Wisconsin, about 30 miles from Milwaukee. A going practice, being taken over temporarily by another physician. Modern office, equipment like new. Available immediately. Address replies to Box 601 in care of the Journal.

WANTED: Young general practitioner to associate in general practice. No immediate investment required. Opportunity to take over entire practice as soon as desired. In village of 1,200 population. Excellent hospital in nearby city. Address replies to Box 602 in care of the Journal.

FOR SALE: Office equipment, complete, for 5 rooms. Includes portable (Fisher) x-ray machine, examining table, and new waiting room set. Address replies to Box 603 in care of the Journal.

FOR RENT: Office space for general practitioner. Desirable residential location. Ample parking space. Office will be arranged to suit tenant. Ample space for consultation room and 3 examining rooms. Write E. J. Kilkelly, Kilkelly's Rexall Drug Store, 7505 Sheridan Road, Kenosha, Wis.

FOR SALE: One Keleket multicron, 100 MA x-ray, complete with timer, tube, and Bucky table. Also included are 5 speed screens and cassettes, one Keleket wallmount, and darkroom equipment. Equipment 4 years old. Cost of equipment, roughly $5,000; will sell for $2,000. Address replies to Box 604 in care of the Journal.

FOR SALE OR RENT: Home above large, five-room, well-equipped office with prosperous general practice. All on large landscaped lot (Wauwatosa, a Milwaukee suburb) just 10 minutes from the Braves' stadium and State Fair Park. Lease, $300 per month with option, $20,000 to buy. Owner specializing. Phone Bluemound 8–4353 or address replies to Box 605 in care of the Journal.

WANTED: Young general practitioner to associate in established general practice located in large southeastern Wisconsin city. Write full particulars in first letter. Salary to start. Address replies to Box 606 in care of the Journal.

FOR SALE: Office equipment and furniture. Owner leaving for residency. Contact J. N. Dockery, M. D., 3333 Erie Street, Racine, Wis.

LOCUM TENENS WANTED for July and August in resort community. Salary and percentage. Write Dells Clinic, Wisconsin Dells, Wis.

OTOLARYNGOLOGIST, board eligible, university trained, with experience in plastic and neck surgery and 2 years' training in eye, desires partnership or association with group. Married; veteran, category 4. Available July. Address replies to Box 607 in care of the Journal.

FOR SALE BY WIDOW OF PHYSICIAN: Equipment including instruments, examining table, hyfrecator, scales, etc. Purchased within last year. Contact Mrs. Louis Reis, 701 Seneca Place, Madison, Wis.

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The Placement Service of the State Medical Society has registered with it a number of specialists in various fields as well as general practitioners. Contact the Placement Service by writing Box 1109, Madison, Wisconsin.

THE WISCONSIN MEDICAL JOURNAL

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Volume 54 JULY 1955 Number 7

Early Roentgen Evaluation of Gastrointestinal Bleeding*

By ALBERT M. KOHN, M. D., GENE W. SENGPIEL, M. D., and JOSEPH F. WEPFER, M. D.

Milwaukee

IN THE past, because of the fear of causing further hemorrhage and because precise knowledge as to the cause of bleeding had little practical importance in the management of gastrointestinal hemorrhage, early roentgen examination was not done. With the passage of time, the accumulation of knowledge and clinical experience did much to change this situation. First, early feeding of the bleeding patient became a therapeutic procedure of proved merit. Second, clinical-pathological studies disclosed the fact that the majority of patients who bleed to death do so from one of three pathological lesions; namely, gastric ulceration along the lesser curvature, peptic ulceration on the posterior wall of the duodenum, and ruptured esophageal varices. Finally, with the development of newer gastrectomy technics and multiple whole blood transfusions, a surgeon who knew which of the three aforementioned lesions was the cause for the hemorrhage could operate and reasonably expect to save the patient who would have otherwise literally bled to death under medical observation. Where exact knowledge as to the cause for hemorrhage had been of little importance in the management of gastrointestinal hemorrhage, now it became a cardinal feature. These were the events and circumstances that led to the exploration of the feasibility of early roentgen examination of the bleeding patient and to its subsequent establishment as a diagnostic procedure of great value. Following the pioneer work of Hampton and Schatzki, there has been much interest in this problem; and the literature contains reports on all phases of the early roentgen examination of the bleeding patient.

* From Department of Radiology, St. Joseph's Hospital, Milwaukee.

TABLE 1—Diagnosis in 123 patients who had roentgen examination to determine cause of bleeding

Day on Which Examination Was Done	No. of Cases	No. of Cases with Positive Diagnosis	No. of Cases without Diagnosis	Per Cent of Cases with Positive Diagnosis
1	25	18	7	72.0
2	24	18	6	75.0
3	17	13	4	76.5
4	23	16	7	69.6
5	7	4	3	57.1
6	6	5	1	83.3
7	9	6	3	66.7
7 plus	12	9	3	75.0

Patients

One hundred and sixty-nine consecutive patients with upper gastrointestinal hemorrhage admitted to St. Joseph's Hospital, Milwaukee, between July 1, 1950, and Oct. 1, 1953, were reviewed. In this group were 123 patients who had a roentgen examination to determine the cause of the bleeding (Table 1). In compiling the findings the cause was considered established and a positive diagnosis was made only when a lesion was unequivocally demonstrated on a purely objective roentgen basis. A roentgen examination with questionable findings was counted as one failing to demonstrate a lesion. There were no criteria for inclusion in this series other than admission to the hospital for upper gastrointestinal hemorrhage and roentgen examination to determine the cause. During this study the sole reason for not doing a requested examination was the presence of severe shock. There were no repeat examinations during the period of hospitalization, and the only positive confirmation came from one autopsy and 6 patients who were treated surgically.

The figures and data presented reflect the findings in a large group of noncharity pa-

tients whose private physicians felt early roentgen examination was important in the management of their particular cases. The paper points out what the private practitioner should expect to experience with early examination of the bleeding patient in the larger private type of general hospital.

Examination

The examination of the patients was performed on a fluoroscopic table which could be tipped into an upright position and which was equipped with a spot film device. The barium used for the examination consisted of U.S.P. barium sulfate and water mixed in approximately equal parts. This mixture was prepared immediately prior to the examination and was of such viscosity that it could easily be drawn through a drinking tube.

The patient was placed supine on the fluoroscopic table and then tilted from the horizontal position to as close to an upright position as his condition permitted. After a cursory survey of the chest had been made, the patient was requested to take two swallows of barium. The barium was observed as it passed through the lower portion of the esophagus into the stomach so that mucosal relief of the lower esophagus was visualized. The patient was then asked to perform the Valsalva maneuver, and the lower esophagus and fundus of the stomach were observed for the appearance of varicosities. Spot films were made at this time. In none of our patients did the Valsalva maneuver demonstrate varicosities which had not been previously visualized. However, it was extremely useful in moving the bolus of barium distally along the magenstrasse and in spreading it over the gastric mucosal folds. By having the patient perform the Valsalva maneuver several times and combining this with rotation of the patient on his long axis, it was usually possible to do a very satisfactory mucosal study without palpation. If the mucosa of the antrum was not well visualized, the patient was returned to the horizontal position to take advantage of the natural compression of this region by the spine. In an upright position or as close to it as his condition permitted, the patient drank the remainder of the 6-ounce cup of barium mixture. The entire esophagus was screened, and the lower esophagus and fundus were again observed for the presence of varicosities. The outline of the barium-filled stomach was then studied in the upright; recumbent; and, if indicated, Trendelenburg positions. If the duodenal bulb filled during this time, it was studied and care was taken to watch the barium as it traversed the second and third portions of the duodenum. With barium in the duodenal bulb, the patient was examined in the left posterior oblique position to obtain an air contrast study of the antrum and duodenal bulb. He was then placed in the prone position, and the curvatures and fundus were restudied in the oblique and lateral positions. During these various maneuvers, spot films were taken at the discretion of the examiner.

Although the examination was outlined in a definite order and the patient examined in the positions described, the exact order was varied to suit the individual case. The guiding principle was to perform the examination in a manner which would allow the least amount of motion and discomfort to the patient and result in optimum visualization of the upper gastrointestinal tract. Gentle palpation was performed only when the examiner felt it to be an absolute necessity.

Findings

There were 92 males and 31 females in this series. The ages ranged from five months to 80 years. Surgery in 6 patients confirmed the roentgen diagnoses—3 cases of duodenal ulcer, 2 cases of gastric ulcer, and 1 case of no lesion. One autopsy reconfirmed both the radiological and the surgical diagnosis of duodenal ulcer.

The findings on roentgen examination at our hospital are summarized in Table 2, where they also are compared with several other reported series. Duodenal ulcer was found in 66 patients, or 53.7 per cent of those examined, and of special interest was the occurrence of two postbulbar ulcers. The incidence of gastric ulcer was 12.2 per cent. Marginal ulcer occurred in 2 patients, or 1.6 per cent. Carcinoma was found in 3 patients, or 2.4 per cent. Esophageal varices were demonstrated in 1 patient. Other lesions reported but not considered to be the cause for hemorrhage were: swollen rugae associated with hypersecretion in 9 patients, hiatus hernia in 6 patients, large duodenal diverticula in 4 patients, and prolapsing gastric mucosa in 3 patients.

Comments on Findings

A duodenal ulcer was found in 66 patients; this finding compares favorably with the figures in the table for other reported series. Of interest was the occurrence of two postbulbar ulcers, which are of the type stated to be more often associated with severe gastrointestinal hemorrhage than with the less severe types. The incidence of gastric ulcer was 15 cases, or 12.2 per cent, which is lower than that in most reported series, including those in the table. It is true, however, that most of these series were more highly controlled than ours and contained a higher percentage of cases with severe bleeding by virtue of the criteria which were used in the selection of cases. In the most severe hemorrhages; that is, those which were fatal, the incidence of gastric ulcer was high (32 per cent in the autopsy series). The criteria for inclusion in the series listed in Table 2 are most rigid for the series on the left and become less rigid for each series to the right. Likewise, the incidence of gastric ulcer is greatest in the first series and decreases in each succeeding group. Further, it should be noted that patients in these larger series come from larger county and city hospitals, and the type of patient may have had some bearing on the incidence of the various lesions. A good example of this type of effect was the incidence of esophageal varices, which were demonstrated in only 1 case in our series. This is not too remarkable when one considers that there were only 2 cases of cirrhosis in the series.

The lesion presenting the largest apparent discrepancy in the comparative series was gastritis. In our series there was not a single instance in which gastritis was considered to be the cause for hemorrhage. The reasons for this were: (1) There were no repeat examinations during the period of hospitalization, and a diagnosis cannot be made accurately on the basis of a single examination and (2) To quote Schatzki, "The demonstration of gastritis is difficult, and to demonstrate errosive gastritis (the type most likely to bleed) is extremely difficult. It is in fact only rarely accomplished. Alcoholic gastritis is associated with a swelling of the rugae and hypersecretion which is a nonspecific finding and more often present in patients without bleeding." For these reasons, findings suggestive of gastritis, including swollen rugae with associated hypersecretion, were reported if present but were not considered as the cause for gastrointestinal hemorrhage. The clinician was at full liberty to draw his own conclusions.

TABLE 2—Findings on roentgen examination in our series compared with findings in three other series

Lesion	Boston-101 Autopsies*	Boston-123 (Clinical)**	Cleveland-58 (Clinical)***	St. Joseph's Hospital, Milwaukee-123 (Clinical)
Duodenal Ulcer	24.0%	53.0%	39.0%	53.7%
Gastric Ulcer	32.0%	21.0%	17.2%	12.2%
Esophageal Varices	33.0%	16.2%	6.8%	0.8%
Gastritis	2.0%	32.0%	3.2%	0.0%
Stomal Ulcer	0.0%	1.6%	0.0%	1.6%
Malignancy	6.0%	4.0%	3.4%	2.4%
No Lesion Found	7.0%	4.8%	24.1%	27.6%

*A series of 101 autopsies at Boston City Hospital. Chalmers, T. C., Zamcheck, N., Curtins, G. W., and White, F. W.: Fatal gastrointestinal hemorrhage: clinicopathologic correlations in 101 patients, Am. J. Clin. Path. 22:634–645 (July) 1952.

**A series of 123 patients with acute, massive gastrointestinal hemorrhage. Zamcheck, N., *et al.*: Early roentgen diagnosis in massive bleeding from the upper gastrointestinal tract, Am. J. Med. 13:713–724 (Dec.) 1952.

***A series of 58 patients with gastrointestinal bleeding. Elmer, R. A., Rousuck, A. A., and Ryan, J. M.: Early roentgenologic evaluation in patients with upper gastrointestinal hemorrhage; report of 58 cases, Gastroenterology 16:552–565 (Nov.) 1950.

Included in the findings but not considered the cause of bleeding were hypersecretion associated with swollen rugae in 9 patients, hiatus hernia in 6, large duodenal diverticula in 4, and prolapsing gastric mucosa in 3 patients. These are usually incidental findings and are so regarded in most of the reports in the literature. There are reported, however, well-documented scattered cases of gastrointestinal hemorrhage which have resulted from the aforementioned lesions.

There were also a considerable number of patients in whom no etiological lesion was found. One patient of this type was explored surgically, and the roentgen findings were confirmed when no lesion could be demonstrated. Making allowances for the clinical material studied, we find that our percentage of cases in which no cause was found for bleeding is not too different from corresponding percentages in some other series. Referring to the findings in Table 2, we note our 27 per cent compares well with the figure from the clinical series reported from Cleveland City Hospital.

It is also interesting to note that in those patients in whom the bleeding was severe and shock was a prominent feature the incidence of failure to demonstrate the lesion dropped to 6.3 per cent (one failure in 16 patients).

For the purpose of comparing the incidence of the various lesions, and the number of positive findings, when considered in terms

TABLE 3—Comparison of findings in patients examined within 96 hours with findings in those examined after 96 hours

	Within 96 Hours	More than 96 Hours	Totals
Duodenal Ulcer	48	18	66
Gastric Ulcer	11	4	15
Postbulbar Ulcer	2	0	2
Carcinoma	3	0	3
Varicosities	1	0	1
Stomal Ulcers	0	2	2
Total	65	24	89
No Diagnosis	24	10	34
Grand Total	89	34	123

of the day on which the examination was done, the series was divided into two groups —those examined within 96 hours and those examined after 96 hours. The results are found in Table 3. From the data, at least one conclusion may be drawn. Delaying the examination for just a few days does not increase the likelihood of finding a cause for the hemorrhage. Further, in accordance with what has been reported in the literature about the rapid healing of acute peptic ulceration, the figures seem to suggest that there might be some advantage in early examination.

Comments on Examination

In general, the examination was not as easily accomplished in the patient in whom the hemorrhage had been severe. Nevertheless, limitations imposed by the patient's condition at the time of the examination did not make a single examination impossible. As in the relatively well patient, size and habitus contributed greatly to the ease or difficulty of the examination. In this series, presence of blood or clots was not often encountered and, when present, did not complicate the examination to the point where it was felt to be grossly inadequate. Early examination of the bleeding patient did not jeopardize his safety. In only 3 patients was there any question of the recurrence of hemorrhage immediately following the examination. In these cases the patients reported a feeling of extreme weakness, and blood pressure and pulse changes were present. Although there is always the question of coincidence, the examination may have had some relation to the hemorrhage. In 2 patients the episode was very transient. In the third, there was shock and the subsequent passage of grossly bloody stools. In all cases, however, the subsequent course was uneventful.

Conclusions

1. Early roentgen examination of the bleeding patient demonstrates the cause of bleeding in the majority of cases. Further, the diagnosis can be made in an even higher percentage of cases when symptoms are manifest and the bleeding comes from a source which is prone to give rise to fatal hemorrhage.

2. Early examination entails no appreciable risk to the patient's safety.

3. In spite of thorough examination, the cause of hemorrhage will remain a mystery in many cases.

4. Making allowances for statistical variation and the fact that this is a completely uncontrolled study, there is no appreciable difference between the relative incidence of the various lesions as reported in the literature and their incidence as demonstrated in this study.

5. Because it is a safe, reliable, and accurate procedure, early roentgen examination of the bleeding patient is recommended to every practitioner concerned in the management of gastrointestinal hemorrhage.

(A.M.K.) 4888 North 21st Street.

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Paroxysmal Nocturnal Hemoglobinuria

By GEORGE W. DEAN, M. D.
Milwaukee

OF THE many kinds of hemolytic anemia, one of the rarest and most dramatic is paroxysmal nocturnal hemoglobinuria. This disease, which we will refer to as P.N.H., is also called the Marchiafava-Micheli syndrome. Its cause is unknown, but the basic defect has been found in the erythrocytes, permitting them to be hemolyzed by the patient's own serum and by the serum of a normal individual.[1] P.N.H. was recognized by van den Bergh in 1911 and by Chauffold and Troisier in 1908, but the earliest clear descriptions of the condition were given by Marchiafava in 1928 and by Micheli in 1931. Ham[2] devised the acid hemolysin test which is considered specific for this disease. Crosby[3] says about 160 cases were reported up to 1953. We wish to add one more.

Case Report

The patient, a white woman, 60 years old when first seen in July 1952, was admitted to the hospital because of recurrence of bronchial asthma which had bothered her at intervals since 1944. This responded well to treatment, but in the course of her examination she gave a history of anemia since the birth of her child in 1927, and of episodes of "dark urine" since 1940, accompanied by jaundice in recent years.

In 1948, after a siege of jaundice, she was found to have a normal cholecystogram; and a biopsy of the gallbladder was done. The pathologic diagnosis was "diverticulum of the gallbladder." In 1951 she had a severe attack of atypical or virus pneumonia accompanied by heart failure, presumably due to cor pulmonale. The liver was enlarged 10 cm. below the costal margin. She had a pronounced anemia that was not classified. There was no family history of "dark urine." Her mother died of carcinoma of the liver at the age of 54 and was jaundiced for one year prior to her death.

The physical examination was normal except for prominence of veins of the lower abdomen. No neurological abnormalities or evidence of venous thromboses were found.

Laboratory studies included the following:

- Urobilinogen, 0 to 1.5 mg. per cent
- Urine porphyrins, trace; sugar, none; Bence-Jones protein, none
- Fasting blood sugar, 93 mg. per cent
- Serum proteins, total 9.3 Gm., albumin 5.25, globulin, 4.02, ratio 1.3:1
- Serum bilirubin, direct 1.3 mg., indirect 3 mg.
- Cholesterol 232, esters 113.5
- Alkaline phosphatase 1.45 units, phosphorus 4.55 mg. per cent
- Prothrombin, 69 per cent of normal
- Red blood cell fragility, normal
- Coombs' test negative, Donath-Landsteiner test negative

Normal liver cells were seen in the specimen obtained by a needle biopsy of the liver, and no iron pigments were seen in a skin biopsy.

The erythrocyte count before the transfusion was 3,590,000, the hemoglobin 75 per cent, leukocytes 5,900, differential count normal. After the transfusion her erythrocyte count was 3,930,000 and the hemoglobin 81 per cent. The Ham's acid hemolysis test was positive at one time but negative at another, and a thrombin activation test was positive on several occasions.

The clinical diagnosis of paroxysmal nocturnal hemoglobinuria was made at this time.

After leaving the hospital, the patient continued to have severe attacks of P.N.H. about every two months; these alternated with milder attacks. She could almost predict the appearance of the "dark urine" and would become apprehensive and discouraged at the time it approached. The hemoglobinuria always appeared after a period of sleep, day or night, and was usually preceded by "indigestion." Several of the attacks apparently were precipitated by an acute upper respiratory infection. However, the patient had had these infections without the P.N.H. For each of the severe spells, she was hospitalized and on most of these occasions was given four transfusions of 500 cc. of whole

blood, or four units of washed erythrocytes. She apparently responded as well to the whole blood as to the washed erythrocytes. There was no evidence of increased hemolysis following transfusion. In fact, the contrary seemed to be true; the hemolysis ceased more quickly when transfusions of whole blood were given early in the episode.

On Nov. 17, 1954, during a bout of P.N.H., complete blood studies were done by Dr. A. V. Pisciotta[4] of Marquette University School of Medicine, Milwaukee. He reported the following:

Coombs' antiglobulin test, 1+ positive
Donath-Landsteiner test (cold hemolysins), negative

Hemolysin determinations:

Fresh AB human serum used as diluent and source of complement.

Patient's serum—patient's fresh cells, negative
Patient's serum—patient's trypsinized cells, 1+ hemolysis
Control serum—patient's fresh cells, negative
Control serum—patient's trypsinized cells, 1+ hemolysis
Patient's serum—control fresh cells, negative
Patient's serum—control trypsinized cells, negative

With guinea pig complement:
Exactly same results as above

Acid hemolysin, pH 6.4
Control serum and patient's cells (fresh and trypsinized) and guinea pig complement, 1+ positive
All controls, negative

These determinations could not be repeated on November 19 because of spontaneous hemolysis of the patient's erythrocytes.

Mechanical fragility
Fresh, 6.9 per cent
24 hours, 44.4 per cent
Fetal hemoglobin, 0.8 per cent
Electrophoretic pattern of hemoglobin, type A (normal)

These results indicated that when the patient's red blood cells were treated with trypsin, they were susceptible to hemolysis by at least one factor present in normal serum as well as acidified serum, thus proving the diagnosis of paroxysmal nocturnal hemoglobinuria.

On Jan. 11, 1955, the patient contracted a mild upper respiratory infection and on the following morning noted the reappearance of the hemoglobinuria. The respiratory infection rapidly became worse, and on January 15 she was readmitted to the hospital. She became deeply jaundiced and pallid and in spite of intensive treatment died on January 16.

Anatomic diagnoses at autopsy were: (1) mucopurulent tracheobronchitis; (2) pulmonary emphysema, obstructive type; (3) bronchiectasis; (4) atelectasis, right middle lobe; (5) cor pulmonale; (6) chronic rheumatic valvulitis; (7) cardiac cirrhosis of the liver; (8) hemoglobinuric tubular nephropathy; and (9) uterine leiomyofibromata.

Discussion

The etiology of P.N.H. is not known. There is no familial or hereditary factor and no apparent racial influence. It is usually found in young adults but may occur in the extremes of age. The distribution between sexes is about equal, and there is no known occupational relationship. Infections, riboflavin, and acetylsalicylic acid,[5] as well as a wide variety of other things, have been implicated.[3] These include arsenicals, Evans blue dye, nitrogen mustard, various vitamin preparations, peptone, typhoid vaccine, bicarbonate of soda, ammonium chloride, potassium nitrate, and quinine. Physical injury and emotional disturbances are thought to be factors. Crosby believes transfusion of whole blood may precipitate hemolysis.

The basic defect in P.N.H. appears to be in the erythrocyte itself, probably in the stroma, which may be unusually sensitive to a normally present, thermolabile, hemolytic enzyme. This increased sensitivity perhaps is augmented by slight changes in the pH of the serum. The hemoglobin in P.N.H. is normal. Hemolysis of the erythrocyte will occur in the serum of the P.N.H. subject as well as in the serum of a normal individual, and the erythrocyte of a normal subject will not be hemolyzed in the serum of the P.N.H. subject. Hence, normal cells transfused into a P.N.H. subject will not be hemolyzed, whereas the erythrocytes of the P.N.H. subject transfused into a normal subject may undergo hemolysis. Crosby says that hemolysis is under the control of an excitatory and an inhibitory factor, the latter being sensi-

tive to thrombin; therefore, thrombin can destroy the inhibitory factor and accelerate hemolysis, this hemolysis being limited to P.N.H. cells.

Much emphasis has been placed upon the importance of pH changes toward the acid side in precipitating crises of P.N.H. It has been assumed that the lowering of the pH during sleep causes the hemolysis and the resulting hemoglobinuria. However, even though hemolysis can be produced *in vitro* in the laboratory by acidifying the serum as in performing the Ham test, a crisis has not yet been produced *in vivo* by administering acid substances, nor has one been prevented by the administration of alkalis.

Erythrocyte destruction is a constant process. Aged and damaged red blood cells are removed from the circulation, largely by the spleen, after an intravascular life of about one hundred twenty days. Normally, small amounts of hemoglobin are present in the serum; the usual level is 5 mg. per 100 ml. With sudden and massive intravascular hemolysis, large amounts of free hemoglobin are released into the serum, resulting in hyperhemoglobinemia. Some of the free hemoglobin is taken up by the reticuloendothelial system and converted into bilirubin, with consequent hyperbilirubinemia; some is converted into hemosiderin; and the remainder is probably released into the serum as free iron, globin, or globulin. Since hemosiderin appears in the urine when the level of hemoglobin in the plasma is abnormally high, hemosiderinuria is a valuable diagnostic sign of hemoglobinemia.[6]

The excess hemoglobin that remains in the serum and is not disposed of by one of the channels mentioned above acts as a threshold substance and, when the serum level reaches a certain height, will appear in the urine. The serum level at which hemoglobin will appear in the urine according to Ottenberg and Fox[7] is 30 mg. per 100 ml. Gilligan *et al.*[8] found the renal threshold for injected hemoglobin to be 135 mg. per 100 ml.; but once hemoglobinuria appeared, it persisted until the serum level had dropped to 30 to 50 mg. per 100 ml. Crosby[3] says the renal threshold is 50 to 100 mg. per 100 ml.

The excess of hemoglobin turns the urine mahogany red, brown, or black. The color is not diagnostic, but laboratory studies will reveal the cause of the discoloration. In hemolytic processes, hemoglobinuria is not always constant; but increased serum hemoglobin and hemosiderinuria are persistent findings in P.N.H. since the excessive destruction of erythrocytes is continuous.

The hyperbilirubinemia causes jaundice accompanied by a positive indirect van den Bergh reaction, increased fecal urobilinogen, increased urinary urobilinogen, the absence of bile pigments in the urine, and the presence of bile pigments in the stool. In uncomplicated cases, liver function tests and gallbladder studies are normal.

The clinical course of P.N.H. is that of a chronic hemolytic anemia, with acute hemolytic crises which in some patients occur at fairly regular intervals. While the onset of P.N.H. may be abrupt, the first appearance of "dark urine" making it seem so, the patient probably suffered with a chronic anemia or unexplained jaundice previously. In addition to the specific symptoms during a crisis, the patient usually experiences vague abdominal pains over the liver or spleen, pain in the lumbar area, drowsiness, malaise, and anorexia. There is often a feeling of depression and discouragement over the reappearance of a condition which the patient hopefully felt had been overcome. This symptom was especially prominent in our patient. Symptoms as a result of thromboses occur frequently, especially in the cerebral and portal systems. Among such symptoms are headache, vertigo, aphasia, transient paralysis, pain over the liver area, enlargement of the liver, and evidence of collateral circulation such as ascites or engorgement of the abdominal veins. Thromboses are thought to occur because the platelets are sticky and adhere to the vascular wall, as in thrombohemolytic thrombocytopenic purpura.

Between crises the patient does not feel up to par because of persistent anemia. The degree of anemia is variable. Individual patients establish a level at which the blood count remains during remissions. In P.N.H., considerable iron is lost during a crisis, whereas normally very little iron is lost in the process of erythrocyte destruction and regeneration. There have been reports of aregenerative crises in which the bone marrow seems incapable of restoring the formed elements above the level of a moderate pancytopenia.

The course of P.N.H. is long and ultimately ends in death in most instances. Some patients have a permanent partial or complete remission.[3] Usually the crises become more

severe and more frequent and the patient's recovery slower. Death is most frequently the result of infections or thromboses. A complication deserving of special mention, particularly in view of the frequent trial of corticoid hormones in this disease, is peptic ulcer. It is necessary for the physician to be on the alert for symptoms of the occurrence of, or the reactivation of, peptic ulcer as a result of the influence of the corticoid hormones.

The pathological findings in 16 cases were reported by Marks,[9] who described multiple thromboses in the smaller vessels throughout the body. In this series the liver was normal in 40 per cent of the patients, while in others there were noted central necrosis, thrombosis of the small portal veins, and congestion of the small central veins. The spleen was normal in 50 per cent of the cases and, in the rest, was enlarged to some degree, with hyperplasia and congestion. During life the liver and spleen usually are enlarged during a crisis. The kidneys contain deposits of iron chiefly in the ascending loop of Henle and in the distal convoluted tubules. The pigment can be seen grossly in the cortices and in the interpyramidal substance but not in the pyramids. The kidney often has the color of mahogany. The exclusive selection of the kidney for the deposit of iron is a distinctive characteristic of P.N.H., since in other diseases involving iron storage —diseases such as hemosiderosis and pernicious anemia—the pigment can be found in many organs. The deposit of pigment in the kidney is apparently harmless since renal function tests have been normal whenever they were done. Crosby reports that proteinuria usually precedes hemoglobinuria, but the significance of this finding is not known.

While it has been found that the defect in P.N.H. is in the erythrocyte, the nature of this defect has not been determined. In a typical case, the anemia is normocytic or macrocytic with anisocytosis and poikilocytosis, and frequently reticulocytosis during the regenerative phases. Neutropenia, leukopenia, or thrombocytopenia may occur, especially if the spleen is enlarged. The hemoglobin is normal, erythrocyte fragility is not altered, and the Coombs' and Donath-Landsteiner tests are usually negative. The Ham acid-hemolysis is considered by some to be specific, but it may be positive at one time and negative at another,[3] as in our patient. Crosby considers the thrombin activation test specific for this condition, but it has not been reported in any large series. It was positive in our patient several times.

Because the hemoglobinuric phase is not constant, the diagnosis may be difficult. Hemolytic anemia may precede by many years the hemoglobinuria which eventually leads to the proper diagnosis.[10] The Ham test, and the thrombin activation test as described by Crosby[11] will serve to differentiate P.N.H. from other types of hemolytic anemia. The morphology of the erythrocyte is not of diagnostic value and usually reflects only rapid blood regeneration. Several writers have reported leukopenia, and Merliss[5] called attention to the frequent association of leukopenia and splenomegaly.

The importance of differentiating P.N.H. from other types of hemolytic anemia must be stressed since the prognosis and therapy vary considerably. Once the hemolytic nature of an anemia has been recognized, steps must be taken to determine whether it is an intrinsic type in which there is an intracorpuscular defect resulting in hemolysis such as congenital hemolytic anemia (congenital hemolytic jaundice, chronic acholuric jaundice, spherocytic anemia), sickle cell anemia, Cooley's anemia (Mediterranean anemia, thalassemia major), and P.N.H., or on the other hand, the extrinsic type in which hemolysis is caused by extracorpuscular agents such as chemicals, drugs, animal or vegetable poisons, infectious agents, isoagglutinins normally present as in erythroblastosis fetalis, hemolytic-immune bodies such as cold hemagglutinins associated with certain infections, and autohemolysins as seen in paroxysmal cold hemoglobinuria (often associated with syphilis). Felty's syndrome of arthritis, splenomegaly, and leukopenia is often benefited by splenectomy.

The treatment of P.N.H. is unsatisfactory, and no cures have been reported. Most observers believe that splenectomy is of no benefit and may even be harmful, although Andersson[12] reported a patient in whom the attacks of P.N.H. were much less frequent and the anemia between attacks less severe after splenectomy. Splenectomy is a formidable operation at best and doubly so for P.N.H. patients. ACTH and cortisone have resulted in no benefit in any cases reported.

Kalant and Cyr[13] reported a patient who was given adequate treatment with intravenous ACTH with no benefit but who did seem improved after Dicumarol. Epinephrine during an attack appears to check hemolysis temporarily but only for brief periods. Transfusion, especially of washed erythrocytes, serves as replacement therapy since the transfused cells are not affected by the hemolytic process. The value of Dicumarol is questionable; Crosby[3] favors it since he feels that it blocks one of the steps in the hemolytic process. It may also be of value in preventing one of the more serious complications; namely, vascular thrombosis. Our patient had allergic manifestations, but their relation to her P.N.H. was not established.

It is reasonable to assume that alteration of the pH of the serum would be effective in preventing or terminating attacks of P.N.H., but no success with this measure has been reported. The administration of oxygen during periods of sleep has also met with failure.

Summary

A case of P.N.H. in a patient who also had severe bronchial asthma and pulmonary emphysema is reported. The importance of accurate diagnosis in formulating the prognosis and treatment is stressed. The common clinical manifestations and laboratory findings are described, and some of the opinions about pathogenesis and treatment are presented.

425 East Wisconsin Avenue.

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BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the last half of 1955 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who are referred by their family physician for orthopedic diagnosis and consultation. Reports of the examination are then sent to the referring physician following the clinic. Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons desiring clinic services. Medical referral forms are made up for the individual clinics, so requests should specify number of forms wanted and for which clinic they are wanted.

Families who return the signed referral form will be notified of the day and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

Ashland	August 10, 11	Eau Claire	October 10, 11
Wausau	August 24, 25	Sheboygan	October 19, 20
Manitowoc	August 31, September 1	La Crosse	October 25, 26, 27, 28
Marinette	September 7	Rhinelander	November 2, 3
Kenosha	September 14, 15	Fond du Lac	November 18
Superior	September 22, 23	Appleton	December 1, 2
Green Bay	September 29, 30	Chippewa Falls	December 8, 9
Racine	October 5, 6		

Inquiries concerning these clinics may be addressed to The Bureau for Handicapped Children, 146 North, State Capitol, Madison 2, Wisconsin.

The Practical Considerations in the Differential Diagnosis of Jaundice

By I. I. CASH, M. D., M. Sc.
Milwaukee

A RECENT study of 14 patients with jaundice gave us an opportunity to determine the relative value of diagnostic methods currently used in this condition.

The differential diagnosis of jaundice still is not entirely satisfactory. However, a careful examination of the patient, sensible application of appropriate laboratory procedures, and thoughtful interpretation of the data will in most instances provide the correct answer.

Our experience in the diagnosis of jaundice is summarized in the table on the opposite page.

Our clinical diagnoses were in error in three instances (cases 8, 9, and 13), as proved by surgical exploration. Needle biopsy was misleading in three instances (cases 4, 7, and 11), since normal tissue was found. The pathology apparently was not diffuse throughout the liver and was normal at the area in which the biopsy was taken. In two patients (cases 3 and 13), the biopsy revealed structural changes that liver functional tests failed to show. The axiom still holds that structural changes in the liver are not measurable with any degree of accuracy in terms of abnormal function. These experiences prompted us to review the subject of differential diagnosis of jaundice once more.

An understanding of the differential diagnosis of jaundice presupposes a knowledge of metabolism of bilirubin pigment. This will be briefly reviewed. Bilirubin is formed by the breakdown of hemoglobin. This pigment is conjugated with a plasma protein and circulates in the blood as a bilirubin globulin complex. It has been shown that it dialyzes with great difficulty through a membrane and thus it does not pass into the urine. It gives a characteristic diazo reaction only after the serum protein has been precipitated with alcohol; this is the essence of the van den Bergh test. The bilirubin globulin is taken up by the liver cells and excreted in the bile canaliculi as cholebilirubin. Free bilirubin and the salts of bilirubin pass into the intestinal tract, where they are reduced by bacterial action to urobilinogen. Part of the urobilinogen is excreted in the feces; part is reabsorbed into the portal blood and carried to the liver. A small portion is excreted in the urine. The liver oxidizes the urobilinogen back to bilirubin to be re-excreted by the bile ducts into the intestinal tract. This procedure is repeated over and over again and is known as the enterohepatic circulation of bilirubin. Normally, traces of urobilinogen and no bilirubin are excreted in the urine. One should be mindful of the fact that the oral use of antibiotics may curb the bacterial reduction of bilirubin to urobilinogen.

One may consider three different types of jaundice: hemolytic or prehepatic, parenchymatous or hepatic, and obstructive or posthepatic jaundice. In hemolytic jaundice, excessive destruction of erythrocytes overtaxes the capacity of the liver cells to excrete bilirubin. The hepatic efficiency is further decreased by congestion within the biliary canaliculi. The urine will contain no bilirubin but will contain increased amounts of urobilinogen. The incidence of hemolytic jaundice is so small that our greatest diagnostic problem usually is differentiating hepatocellular from obstructive jaundice. The laboratory differentiation between these two types of jaundice is accomplished by tests which will indicate liver dysfunction, in contrast to those tests which will reveal interruption of bile flow.

In hepatocellular damage, the liver cells may be directly attacked by a disease process that renders them unable to excrete bilirubin into the bile canaliculi. This means that tests should be done to determine liver function—the various serum flocculation, hippuric acid synthesis, and cholesterol ester tests. These tests are not positive in all cases of liver dysfunction. About fifteen per cent of patients with liver dysfunction will have normal tests. A point of interest should be noted with regard to the patient with infectious hepatitis. Early in the course of this disease, a greater amount of cholebilirubin reaches the intestinal tract. Since little of the urobilinogen formed in the intestinal tract can be oxidized by the impaired liver cells, much of the uro-

Case No.	Clinical Diagnosis	Liver Biopsy	Operative Findings	Final Diagnosis
1	Cirrhosis of liver	Yes		Cirrhosis of liver
2	Carcinoma of pancreas	Yes	Carcinoma of pancreas	Carcinoma of pancreas
3	Obstructive biliary cirrhosis	Yes	Fibrous stricture of common duct	Fibrous stricture of common duct
4	Cirrhosis of liver	Yes		Cirrhosis of liver
5	Infectious hepatitis	Yes		Infectious hepatitis
6	Infectious hepatitis	Yes		Infectious hepatitis
7	Hepatoma*	Yes	Malignant hepatoma	Malignant hepatoma
8	Cirrhosis of liver	Yes	Calculus obstruction of common duct	Calculus obstruction of common duct
9	Carcinoma of pancreas	No	Chronic relapsing pancreatitis	Chronic relapsing pancreatitis
10	Carcinoma of pancreas	No	Carcinoma of pancreas	Carcinoma of pancreas
11	Infectious hepatitis	Yes		Infectious hepatitis
12	Carcinoma of pancreas	Yes	Carcinoma of pancreas	Carcinoma of pancreas
13	Cirrhosis of liver**	Yes	Calculus obstruction of common duct	Calculus obstruction of common duct and cirrhosis of liver
14	Chronic hepatitis developing in the second week of infectious mononucleosis	Yes		Acute cholangiolitic hepatitis

*Liver biopsy did not reveal a malignant hepatoma.
**Liver biopsy established a diagnosis of cirrhosis of the liver, but the patient's clinical course warranted an exploratory.

bilinogen will then appear in the urine. As the disease progresses, less and less of the cholebilirubin reaches the intestinal tract; and, finally, no urobilinogen is found in the urine. This is sometimes referred to as the intrahepatic block and usually is seen in the second stage of infectious hepatitis. On occasions, patients seen in this stage of the disease may be thought to have obstructive jaundice if the sequence of the events is not well understood.

In obstructive jaundice, the cholebilirubin cannot enter the intestinal tract. Since none of the urobilinogen is being formed in the intestinal tract, the urine will contain no urobilinogen. In the presence of incomplete obstruction, increased or spiking urobilinogen levels may be found due to intermittent obstruction, as is found with a common duct stone producing a ball-valve-like effect. In view of the above clinical features in jaundice, one must know the degree and persistency of jaundice. Persistent, pronounced icterus is usually due to either carcinoma of the pancreas or severe hepatitis, whereas fluctuating jaundice is more often due to a stone in the common duct. Thus, it becomes apparent that the study of bile pigment in the urine and feces will be of considerable value. In addition, one will also find an increase in the amount of alkaline phosphatase in the blood and, in many instances, a hypercholesterolemia. At times it is difficult to differentiate between ductal obstruction and hepatocellular disease because the two conditions may coexist, especially when jaundice has existed for a long time in a patient with biliary obstruction.

It is necessary to understand the functions of the liver and the methods or tests available which will appraise these functions.[1] Included among these are:

a. Those tests which measure the excretion of foreign substances—such as the bromsulphalein excretion

b. Those concerned with the excretion of bile pigments such as the serum bilirubin and pigments found in the urine and feces

c. Those related to metabolism of carbohydrates, primarily the galactose tolerance test

d. Those concerned with metabolism of protein—such as the A–G ratio, thymol and zinc sulphate turbidity, cephalin-cholesterol flocculation, and prothrombin index

e. Tests related to metabolism of fats—such as those determining the ratio between total cholesterol and cholesterol esters in the blood

f. Tests concerned with conjugation and detoxification—such as the hippuric acid synthesis test

g. Miscellaneous tests—such as the alkaline serum phosphatase and the test determining the response of plasma prothrombin to injection of vitamin K.

One should note that the tests which measure the degree of jaundice, such as the serum bilirubin and icteric index, and the fate of bilirubin and its conversion products are not tests of liver function. They measure the amount of interference with the enterohepatic circulation of bile. They do not tell where the interference is. The flocculation tests measure the stability of serum proteins in different solutions. The tendency toward flocculation, precipitation, or turbidity is generally increased with a decrease of serum albumin, an increase in gamma globulins, or an increase in serum lipids. Supposedly, only the liver cells are able to esterify free cholesterol to cholesterol esters. In the normal liver,

two-thirds of the total cholesterol is in an ester form. Thus, in liver damage the esterification is impaired. The cholesterol ester fraction is usually markedly reduced in the presence of extreme liver damage. This makes the determination particularly useful in the recognition of liver cell damage in surgical conditions.[2]

It is important to remember that the reduction of hepatic efficiency is not a symmetrical one. Furthermore, there is a large hepatic reserve in which large numbers of hepatic cells may be destroyed without showing evidence of insufficiency. It has been shown that functional insufficiency is not directly correlated with demonstrable histological changes; in fact, it may exist even in the absence of any pathologic changes. A biochemical abnormality may be detected without demonstrable cytological damage.[3]

What help can one derive from the laboratory tests in the differential diagnosis of jaundice? It must first be clearly understood that a well-taken history and a skillfully performed physical examination can make a correct diagnosis in at least 80 per cent of jaundiced patients. The laboratory findings, if positive, become of further substantiating value; when they are negative, they do not exclude liver disease. A history suggestive of the use of hepatotoxic drugs and of blood products such as plasma, with a prodrome of gastrointestinal upset with griplike symptoms, will point to a hepatitis. The physical findings of prominent abdominal veins, spider angiomata, or splenomegaly will support a hepatic cause. A history of previous attacks of biliary colic-like pain, previous operations on the biliary tract, or progressive jaundice with back pain suggests an obstructive cause.

What laboratory procedures can one judiciously use to substantiate a clinical impression? The following outline may be of help in expediting the intelligent use of available laboratory procedures.

I. Laboratory procedures which indicate the presence of parenchymal liver damage or hepatocellular jaundice:

A. Serum bilirubin
B. Abnormal cephalin flocculation
C. Increased thymol turbidity
D. Increased zinc sulphate turbidity
E. Reduced cholesterol ester ratio
F. Bromsulphalein retention (of little value in jaundice)
G. Poor response of prothrombin time to vitamin K
H. Reduced hippuric acid synthesis
I. Liver biopsy

II. Laboratory procedures which indicate the presence of obstructive jaundice, including cholangiolitic obstruction:

A. Elevated total serum cholesterol
B. Marked elevation of serum alkaline phosphatase
C. Depending upon the degree of biliary obstruction, reduced or absent urobilinogen, reduced or absent fecal urobilinogen
D. Presence of bile in the urine
E. Depressed zinc sulphate turbidity.

If a differential diagnosis cannot be made, there should be no hurry to rush into an operation because there is no need to fear that jaundice which persists for two weeks will harm the patient.[4] Patients with hepatitis tolerate surgery poorly. Thus, it becomes imperative that we give ourselves sufficient time to follow the clinical course to observe what happens to the liver functional tests and to see what repeated measurements of bilirubin and its conversion products in the stool and urine will show.

It is well worth emphasizing that abnormal liver functional tests by themselves do not make a diagnosis. They only indicate liver damage. In other words, they bear the same relationship to the final diagnosis in a case of jaundice as the electrocardiogram does to the final diagnosis in heart disease.

238 West Wisconsin Avenue.

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THE MEDICAL FORUM

SOCIETY TRANSFERS OFFICES TO NEW BUILDING

THE NEW HEADQUARTERS of the State Medical Society of Wisconsin at 330 East Lakeside Street, Madison. It provides approximately 20,000 square feet of working and meeting space. The entrance of the building faces south. The north side of the building borders on Lake Monona.

Madison, July 1.—The transfer of the Society's offices from 704 East Gorham Street on Lake Mendota to 330 East Lakeside Street on Lake Monona went off on June 22–26 without a hitch, but not without some frantic efforts to keep mail and telephone services in operation.

The move, made without mishap to personnel or property, occupied the movers and most of the office staff for the better part of a week. This, of course, does not include several months of preparation in sorting and boxing. Neither does it take into account the several weeks of unpacking, storage and adjustment necessary to become finally settled in the new building.

The new location not only offers spacious new quarters for the conduct of business but plenty of parking area for employees and visiting physicians.

FINISHED BY OCTOBER

The ground floor, which opens directly onto the lake side of the Society property, houses the Blue Shield administrative offices, general services room and supply room, and the kitchen and dining hall. The general services room houses IBM equipment; reproduction processes such as mimeographing; and folding and mailing machines, and has space for a microfilm unit to be obtained soon.

Telephone, electrical and heating service units are housed in the basement. It also provides some space for dead storage.

The top floor provides space for the reception room, two consultation rooms, the secretary's office, a small library conference room, and a number of offices for executive and administrative purposes. In addition, a council room which can be divided three ways by folding doors is being completed. It is expected to be ready for use about mid-October.

The Society's former residence on Lake Mendota is now unoccupied, but sale of the property is being arranged through appropriate real estate channels.

Two More Practical Nurse Schools in Planning Stages for State

Madison, July 11. — Wisconsin may have two more schools for practical nurse training by January, according to C. L. Greiber, Madison, director of the State Department of Vocational and Adult Education.

The possibility of additional schools for practical nursing has been widely explored and encouraged by the Committee on Nursing Education of the Society's Council on Medical Service. Dr. Joseph S. Devitt, Milwaukee, is chairman of the committee.

SUPERIOR SCHOOL "FULL"

Both Fond du Lac and Wausau are contemplating schools. In Fond du Lac, Drs. E. H. Pawsat and K. K. Borsack have been instrumental in arranging meetings to develop necessary support for the school. In Wausau, several physicians are working for the establishment of an advisory committee to develop the school.

The vocational department will provide financial support for the first three years of the school's operation, only if full support from physicians, hospitals, nurses and other groups can be demonstrated.

In Superior, where the practical nursing school has had a slow beginning financially and enrollment-wise, the 1955 fall term is already filled with 90 applicants. This follows a pattern, Greiber states, that new schools take a few years to "catch on," but then usually have more applicants than they can accept.

House of Delegates Pays Tribute to Dr. Sargent

The House of Delegates of the AMA paid tribute in Atlantic City to Dr. James C. Sargent, formerly of Milwaukee, who died in October of 1954.

He was chairman of the AMA's Council on National Emergency Medical Service at the time of his death. Dr. Sargent had served in the House of Delegates or as an officer of the AMA since 1938.

HEALTH INSURANCE GROWTH CONTINUES RAPID RATE

Madison, June 23.—Nearly two out of every three men, women and children in the United States now are protected by voluntary health insurance. The Health Insurance Council made this announcement in releasing the findings of its Ninth Annual Survey of Health Insurance of America as of December 31, 1954.

"This survey shows," the council said, "that many more Americans now have more and better health insurance than ever before. Measured in terms of benefits paid out by insuring organizations in 1954, striking progress was made during the year. And the survey figures indicate continuing progress at rapid rates for the foreseeable future."

WISCONSIN HIGHER

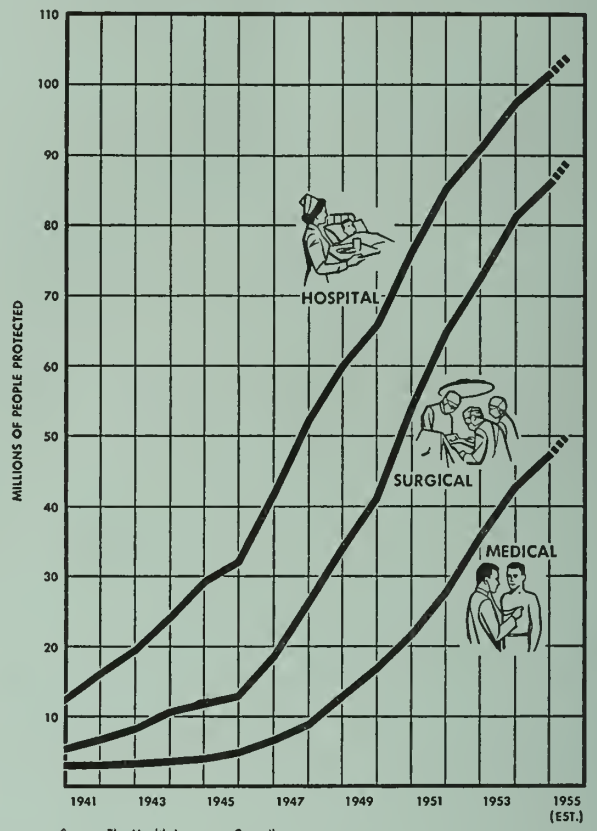
The council estimated that by the end of June, 1955, some one hundred four million persons will have voluntary health insurance against hospital expenses. About eighty-nine million people will have surgical expense protection, and fifty million will have regular medical expense protection. These figures are based on conservative projections of the 1954 year-end data presented in the survey.

Although no information was revealed in the council's report on state-to-state figures, Wisconsin insurance authorities believe that well over two and one-half million people in the state have protection against hospital expenses; and about two million against surgical expenses. Blue Cross alone in Wisconsin protects more than nine hundred thousand persons against hospital expense, and the state's two Blue Shield plans (Wisconsin Physicians Service, Madison, and Surgical Care, Milwaukee) cover a total of almost eight hundred thousand persons for surgical expense.

The total of benefit payments on health insurance claims reported by the survey for 1954 exceeded 2.7 billion dollars, a gain of 11 per cent over the previous year. More than half of the total amount went to help meet hospitalization expenses, and more than 730 million dollars went for surgery and medical care.

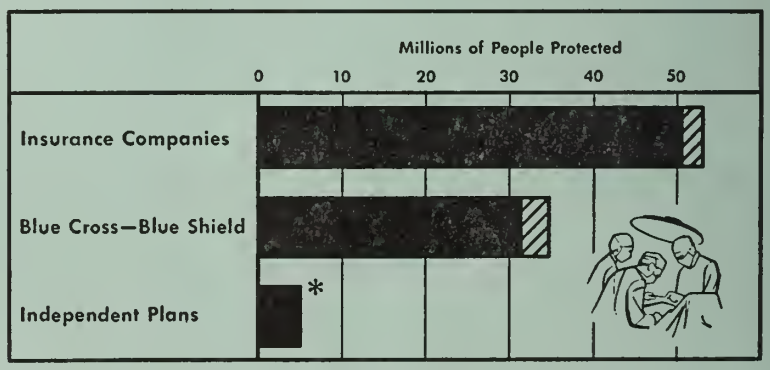
(Continued on page 345)

GROWTH OF HOSPITAL, SURGICAL AND MEDICAL EXPENSE COVERAGE



Source: The Health Insurance Council

DISTRIBUTION OF SURGICAL EXPENSE COVERAGE BY TYPE OF INSURING ORGANIZATION



*Slight decrease in numbers covered during 1954

Numbers covered at end of 1953

Gain in numbers covered during 1954

Source: The Health Insurance Council

Offer Suggestions to Aid in Care of Long-Term Patients

Madison, July 10.—A philosophy of rehabilitation must be paramount in the care of the patient at every stage of his illness, according to a report of the Subcommittee on Hospital Services to the Health Resources Advisory Committee of the Office of Defense Mobilization.

The committee, under the chairmanship of Dr. Howard A. Rusk, Washington, D. C., has made a special study of action necessary to reduce personnel requirements for the care of long-term patients.

The committee has concluded that the kind of care that is most economical in terms of both money and personnel time is the kind of care that returns the patient to his maximum performance as rapidly as possible. This requires more skilled care for short periods rather than prolonged custodial care by less skilled personnel.

To apply that principle, the committee said, requires that a philosophy of rehabilitation be paramount in the care of the patient at every stage of his illness.

Governing bodies of hospitals, certain physicians, hospital administrators and all other health personnel may need additional orientation to the philosophy of rehabilitation before it can be applied on a broad basis.

Inefficient use of personnel results from providing care which is not properly adapted to patients' needs. The physician in charge, according to Dr. Rusk, carries the responsibility for properly interpreting the needs of the individual patient to the rehabilitation team in the hospital.

In addition, cooperative planning by the governing body, medical staff, and the administrator is needed if hospital services are to meet patient needs.

Several approaches should be employed to eliminate the provision of inappropriate services and to substitute appropriate services, including:

(a) Insistence by physicians that their patients' rehabilitation needs receive full attention from the hospital.

(b) Centralization under a single management of leadership, facilities and services for all levels of care, including care in a general hospital (including ambulatory services); chronic unit, preferably in a general hospital; or patient's own home or in a nursing home. The nursing home is a substitute for the patient's own home and not for a hospital.

Unified management will simplify the problem of patient flow to the kind of care that is appropriate. In the absence of centralized facilities and services for all levels of care, formal or informal arrangements between hospitals and nursing care facilities can be attempted.

Development of community referral and counseling agencies to make services available in the community accessible to those who need them and to coordinate the rendering of the services is a vital part of the program.

HEALTH INSURANCE . . .

(Continued from page 344)

Of the total benefit payments in 1954 by all forms of voluntary health insurance, 56 per cent of the total came from the insurance companies. These companies paid over 1.5 billion dollars in benefits, including loss of income benefits.

Blue Cross and Blue Shield type plans paid more than one billion dollars or 39 per cent of the total. Various independent plans accounted for the remaining 5 per cent of the total. The newest form of voluntary health insurance—Major Medical Expense Insurance—is shown by the survey to protect more than 2.2 million persons against the cost of catastrophic illness. This figure represents a gain of 83 per cent during the last year.

A total of nearly 39 million workers had protection at the close of 1954 against loss of income due to disability. This figure represents about 60 per cent of the total civilian labor force in the nation at the time.

The Health Insurance Council consists of nine associations in the insurance business. These associations are in turn made up of companies providing the various forms of protection against hospital, surgical and medical costs, and loss of income due to disability.

OFFER GUIDE FOR PHYSICIANS PLANNING OFFICES

A planning guide for doctors who are establishing a medical practice unit was announced by the American Medical Association in Atlantic City.

The 80-page illustrated brochure is being published through a grant made by the Sears Roebuck Foundation. It contains information for physicians setting up practices, expanding practices or combining with other M.D.'s to develop single medical units.

It is intended that this planning guide will provide a check list for doctors who wish to establish a medical practice unit in a new building, an existing building to be remodeled, or a building to be rented.

Copies are available upon request through the State Medical Society office, P. O. Box 1109, Madison, Wisconsin.

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AMA REVIEWS ACTIVITY ON HEALTH BILLS

Washington, D. C., July 8.—Medical legislation, which had a great deal of interest and support in Congress three months ago, is now being pushed into the background. This was revealed by the quarterly legislative review of the American Medical Association's Washington Office, Frank E. Wilson, M.D., director.

Economy and legal complications account for only part of the changed atmosphere, according to Dr. Wilson. Key health committees were engulfed in Salk vaccine hearings and investigations for many weeks. Activity on vaccine now is subsiding but so much time already has been used up that it will be physically impossible for Congress to process many health bills before adjournment.

BILLS ARE DORMANT

Some of the bills which do not appear to have much chance this year include reinsurance of health insurance plans, guarantee of mortgages for health facilities, and a series of bills dealing with U. S. grants-in-aid.

These bills are dormant, not dead, Dr. Wilson emphasized. They hold their places on legislative calendars, ready to be taken up when the Congress starts its second session next January.

Dr. Wilson lists the following issues which are apt to be important in the few weeks remaining before adjournment:

SALK VACCINE

For weeks, and even months, key health committees were occupied with legislation providing various degrees of federal control over allocation of the Salk antipoliomyelitis vaccine, and various amounts of money to be spent to buy the vaccine either for needy children, or for all under age 19. One bill would amend the biologicals control act to give the secretary of Health, Education, and Welfare (HEW) authority to control distribution and use of biologicals.

Status: Distribution proposals have been aired before Senate and House committees, but no other action has been taken. The bill getting most attention (H.R. 7126) provides for U. S. grants to states to help finance inoculation programs. States would decide what segments of eligible groups would receive special consideration. There could be no means test in public inoculation programs.

AMA Policy: *The association does not oppose limited federal grants to the states for inoculations of needy children, but opposes "all out" federal programs. The AMA is unequivocably opposed to any bill that would place federal control over the* use *of biologicals.*

DISABILITY INSURANCE

What Bill Would Do: Democratic members of the House Ways and Means Committee currently are pushing a plan to amend the social security act to provide cash benefits for disability, to lower the pension age for women, and in other ways to liberalize the law. The committee drafted the bill in closed sessions despite the protests of Republican members. It has voted to report favorably a new bill amending and liberalizing the social security law, including compulsory national disability insurance. There will probably be a strong minority report. Among other things, the bill would extend old age and survivors insurance coverage on a mandatory basis to all self-employed persons, except doctors of medicine.

Status of Bills: The House committee chairman Cooper hopes the bill can be passed this session. Chairman Byrd of the Senate Finance Committee is opposed to passage at this time. A number of similar bills are pending.

AMA Policy: *The association is firmly opposed to disability insurance because: (1) machinery at the federal level to supervise the certification of disability would put the government firmly in the middle of medical practice, and (2) pressures would be applied on physicians by patients for speedy certifications.*

PINCH OF FLESH NEEDLES DOCTORS AS WELL AS CLIENTS

Medical Society Turns That Hurt Problem Into One of Mathematics

By HERB JACOBS

EVERYBODY loves doctors, especially when you are feeling a little sick. But the question today is whether the doctor should pinch or stretch, when it comes to administering that shot—be it a portion of Salk vaccine or a hypo to ease the agony of a hangover. I am referring to the portion of flesh into which the medico is preparing to insert a needle.

A woman who said her name wouldn't mean anything to me called up, and said that Dr. E. E. Sevringhaus had told her that if you pinched the flesh, (say of the arm) it hurt when you put the needle in, but if you stretched the skin, it didn't.

"You take it from there!" said she.

HERB JACOBS

Well, I took it to my family physician, who replied, after a period of judicial reflection, that he didn't think it made any difference.

So then I called the State Medical Society of Wisconsin, and presented the problem to them. After several days of silence, I received a phone call, and a secretary with a lovely voice read of the following exordium to me:

"There are as many schools of thought about this matter as there are doctors. However, there are a considerable number of doctors who assert that the needle hurts less when they tell the patient that they are going to count to three, and will push in the needle when they get to three. Only they push it in when they get to two."

If this explanation requires many physicians to alter their mathematical formulas, I am sure that these agile gentlemen will be equal to the occasion.

[Reprinted with permission of the Capital Times, Madison, Wisconsin.]

MILITARY MEDICAL SCHOLARSHIPS

What Bills Would Do: As a partial answer to military medical problems, the Defense Department is proposing full scholarships for medical students. They would be obligated for three years' active duty if scholarship is a year, or five years if scholarship exceeds a year.

Status of Bills: Unless Congress acts shortly, these measures will have to carry over to next Congress.

AMA Policy: *The proposals are supported by the AMA but with three suggested changes: (1) a student not be approached by the military until fully matriculated, (2) no student so selected to receive any preferential treatment, and (3) number of scholarships in a school not to exceed 5 per cent of any year's class or total enrollment.*

MILITARY DEPENDENTS

What Bills Would Do: Still high on the administration's priority list is the plan for a broadened and uniform application of medical care for dependents of all servicemen. This care, within limitations of the military, would be provided in the main by uniformed physicians and military hospitals; where such care and facilities were not available, local physicians and resources would be called on. The Defense Department has been working out details of supplying private medical care on an insurance basis for those dependents unable to use military resources.

Status of Bills: Because of the complexities in the insurance phase of the program, progress has been slow. Some hearings may be held before adjournment, but definite action probably will await next session.

AMA Policy: *The AMA feels Defense Department's emphasis is in the wrong place. The association says that in this country military dependents, like other civilians, should be treated by private physicians and in private hospitals unless these resources are inadequate. Then, and only then, should uniformed physicians and military facilities be employed. Also, the association objects to the use of a special draft law to provide physicians to care for civilians within this country.*

FEDERAL AID TO MEDICAL EDUCATION

What Bills Would Do: Most prominent are identical House and Senate bills for a five-year, $250 million program of grants to schools for construction, expansion, modernization and maintenance. Up to two-thirds of new school construction cost would be supported by the government, and up to one-half of existing school costs; if an existing school increased its freshmen enrollment five per cent over last year, it also could get up to two-thirds.

Status of Bills: Hearings have been held in both Senate and House. All witnesses supported the bills, and favorable reports are expected from both committees. The only question is whether Congress will have time to vote a bill before adjournment. The proposal does not have the endorsement of the administration, which feels that medical schools should not be assisted while the U. S. is not helping other branches of higher education. Bills: S. 1323 (Hill and 12 others) and several others.

AMA Policy: *The association endorses these bills in the belief an emergency condition exists in medical schools. But it proposes dropping out the five per cent enrollment incentive and making certain that the advisory Medical Education Council include six "leading medical authorities" and specialists in finance and construction.*

MENTAL HEALTH SURVEY

What Bills Would Do: Chairmen of the House and Senate committees dealing with health legislation have sponsored identical bills for federal grants totalling $1,250,000 to non-government groups for financing an extensive three-year survey of national mental health problems. The administration would go further and set up a five-year program of grants to states to maintain and improve mental health services and to stimulate special projects.

Status of Bills: The House bill for a survey of mental health has passed the House, and the Senate Labor and Public Welfare Committee has held hearings on a companion bill with prospects that it also will be favorably reported. This bill has little opposition and there is ample time for its enactment. Chances of the administration proposal getting through this session are very small.

AMA Policy: *The association is giving its full support to the national survey bill and also supports the administration's bill, but only as a temporary measure until Congress redefines federal and local areas of responsibility in public health matters.*

FEDERAL EMPLOYEE HEALTH INSURANCE

What Bill Would Do: Most U. S. civilian workers would be eligible for coverage. They would choose between (a) an overall federal plan, to be contracted for nationally by the Civil Service Commission, or (b) a local, employee or other type of plan. Major medical expense coverage also would be available. The U. S. would pay up to $1.50 per month for a single person, or up to $4 for one with dependents, or one-third of the premium, whichever is the smaller. Benefits that would have to be allowed are spelled out specifically in the bill.

Status of Bill: The bill, subject of a year of conferences, was not introduced until July, probably too late for any action this session.

(Continued on page 350)

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DOCTORS NEED TO IMPROVE KNOWLEDGE OF INSURANCE

Commission on Prepaid Plans Elects Officers

Prairie du Chien, June 20.—Five new physician members of the Commission on Prepaid Plans took their places at the commission meeting in Prairie du Chien on June 18–19.

Drs. Milton D. Davis, Milton, and F. H. Wolf, La Crosse, will serve terms ending in 1956, while Drs. D. N. Goldstein, Kenosha, and A. W. Hilker, Eau Claire, will serve until 1958.

Present members reappointed to terms ending in 1958 are Drs. E. M. Dessloch, Prairie du Chien; N. A. Hill, Madison; P. B. Mason, Sheboygan; Richard Foregger, Milwaukee; and G. W. Carlson, Appleton.

APPROVE ADVERTISING

The commission approved a recommendation of its Committee on Physician and Public Relations for a $45,000 advertising program to run from July through December, 1955. The cost will be shared by Blue Shield and Blue Cross. Beginning in July, ads for both plans will be seen in 35 daily newspapers and in buses in three cities, and will be broadcast over 17 radio stations.

During the meeting, Dr. Robert Krohn, Black River Falls, was named vice-chairman; Dr. N. A. Hill, Madison, treasurer; and Dr. John T. Sprague, Madison, assistant treasurer. Dr. Dessloch serves as chairman.

Despite the rapid growth of health insurance protection in Wisconsin, many doctors do not understand the important aspects of insurance, according to a report received by the commission. The report was presented by the Committee on Physician and Public Relations as a result of meetings with 14 county medical societies. Each meeting was attended by a representative of the State Medical Society and a Wisconsin private insurance carrier. They outlined the principles of insurance protection, major problems in coverage, and what can be done to serve the common interests of physicians and the insurance industry.

Among the major conclusions of the conferences were recommendations that:

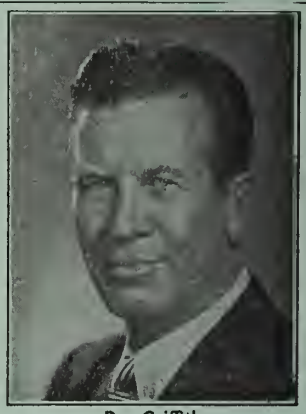
1. Uniform claim blanks be developed as rapidly as possible.

2. The insurance industry seek to eliminate advertising which urges a policyholder to "use the benefits for anything he pleases." Physicians contend this is morally contrary to insurance purposes and encourages dissipation of insurance payments.

3. Overselling by salesmen and advertising be remedied by educational programs and closer supervision of ad preparation.

The commission also approved a recommendation of its Committee on Enrollment and Underwriting that continued efforts be made to enroll non-group subscribers through special "community-type" enrollments.

Dr. Gavin



Dr. Griffith

Dr. Gavin Re-elected Board President

Madison, July 1.—Dr. Stephen E. Gavin, Fond du Lac, was re-elected board president by the State Board of Health at its meeting at Lake Tomahawk State Camp. Dr. Samuel L. Henke, Eau Claire, was re-elected vice-president.

In other action, the board appointed Alvin Langehaug, 2200 W. Kilbourn Ave., Milwaukee, to a three-year term on the advisory hospital council. The board also reappointed as council members, Mrs. John Ramsay, Peshtigo, and Herbert Vonier, Milwaukee. All council terms begin August 1.

The advisory hospital council supervises the administration of hospital construction in Wisconsin which uses Hill–Burton funds.

Governor Confirms Dr. Griffith to Post on Board of Health

Madison, June 25.—Joseph C. Griffith, M.D., Milwaukee surgeon, has been appointed to a seven-year term on the State Board of Health by Governor Walter J. Kohler. Approval of this appointment was voted by the state senate in session, June 22.

Dr. Griffith, who received his medical degree from Marquette University School of Medicine in 1923, is a past-president of the State Medical Society. He has been a member of the society's Council and the Public Policy Committee. He is now a delegate to the American Medical Association.

A past-president of the Medical Society of Milwaukee County, Dr. Griffith is a member of the Milwaukee Academy of Medicine and the Society of Industrial Physicians and Surgeons.

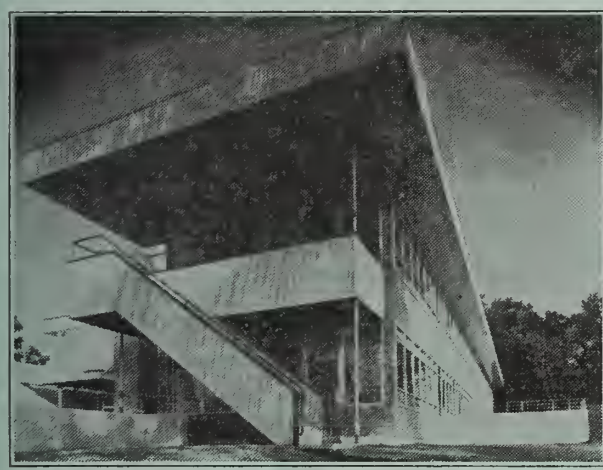
Reproduction of Hippocratic Oath

Madison, July 11.—A striking, two-color offset reproduction of the revered Hippocratic Oath is now available from the State Medical Society, $1 each, postpaid.

The copies are made available through the American Medical Association. Printed on quality Crane parchment stock, the reproduction measuring 11¾ by 15¼ inches is suitable for framing. Many physicians are placing copies of the oath in their offices and reception rooms.

The entrance to the Society's new building.

A view of the Capitol and the State Office Building from the east end of the State Medical Society's headquarters.



The lake side of the new building reveals two stories, 160 feet in length.

Moving for the Medical Society lasted from June 22 through June 26.

Society Develops Insurance Program for Migrant Workers

Madison, July 11.—Another step in arranging adequate hospital-surgical-medical protection for migrant workers has been developed by the State Medical Society.

On June 15, a special arrangement between Canned Foods, Inc., Waupun, and Blue Shield–Blue Cross went into effect to provide hospital and surgical–medical protection for all migrant personnel employed by that company during the summer of 1955.

The arrangement applies to single workers only since these are the only migrant workers employed by this concern.

Similar arrangements have been worked out for a segment of the Oconomowoc Canning Company of Oconomowoc.

The State Medical Society became interested in this problem about a year ago; and through its Commission on Prepaid Plans which directs the operation of the Society's health insurance programs, studies were undertaken which led to the development of a special contract for migrant workers. The contract was placed in effect through Wisconsin Physicians Service, the Blue Shield Plan of the State Medical Society.

Notable steps have been made by the canning industry itself over the past several years to cover many types of migrant workers with some kind of health insurance protection. The Society believes that its venture, while new to Blue Shield, is also a step forward in meeting the needs of the migrant worker in the community.

BLUE SHIELD WINS RIGHTS TO SYMBOL

Chicago, June 23.—John W. Castellucci, executive director of Blue Shield Medical Care Plans announced in Chicago today that the recently tried infringement suits in Texas and Mississippi, involving the well-known Blue Shield service mark and the shield symbol, have been settled. The validity of the Blue Shield service marks has been recognized.

HEALTH BILLS . . .

(Continued from page 347)

However, it is strongly supported by the administration and likely will be acted upon next session.

AMA Policy: *While the association supports the principle in general, and AMA staff people have supplied background information for use in drafting this legislation, copies of this bill have just become available and the AMA has not had an opportunity to study it and take a position.*

TAX DEFERMENTS

What Bills Would Do: Proposals for deferring taxation on money put into restricted retirement plans have been before Congress for some time. They are known as the Jenkins–Keogh–Ray type bills and while there are some variations in details, generally they would allow physicians and other self-employed to pay income tax on the amounts when received as annuity payments. They would merely give the self-employed the same tax advantages as corporation employees.

Status of Bills: House Ways and Means Committee heard a number of witnesses June 27–28 on bills implementing the program. For budgetary reasons the administration opposes their passage now. Whether the bills will be acted upon this session is questionable, but they certainly will be brought up again next session. Bills: H. R. 9 (Jenkins), H.R. 10 (Keogh), H.R. 2092 (Ray) and eight other bills.

AMA Policy: *The association has pressed hard for this type of legislation. The AMA prefers the Jenkins-Keogh bills which were the subject of the House hearings.*

RESOLUTIONS ON TREATY POWER (BRICKER)

What Bills Would Do: There is strong sentiment in Congress for passage of a resolution for a constitutional amendment limiting the Executive Department in the making of treaties and executive agreements affecting internal laws. With this law on the books, domestic legislation could not be enacted simply through a treaty or executive agreement.

Status of Bills: A Senate judiciary subcommittee held extensive hearings on Senator Bricker's amendment in late April and May and reported the bill favorably, but the full committee has not yet acted. The resolution may reach the Senate this session, but final action in that body more than likely will be postponed to next session.

AMA Policy: *The association is a strong advocate in principle of the Bricker concept. AMA maintains that under present law it is possible to impose medical licensure laws or compulsory health insurance through treaties, without Congressional or state action.*

Medical Reports are Key to Determination of Disability

Social Security Office Asks Doctors' Help

Madison, July 11. — Physicians and hospitals have an important part in assisting their patients to get the benefit of a new provision of the social security law which protects a worker's social security record while he is disabled.

A determination that a person is disabled must be based upon medical evidence. The patient himself is expected to secure the initial medical evidence; therefore, he will frequently request a summary of the history, clinical findings, and treatment of his case from his physician or medical facility.

In other cases, the request, along with a release signed by the patient, may come from the state agency responsible for the determination of disability or from the Social Security Administration.

The medical reports will be of considerable help to the patient's welfare if they are completed promptly and accurately with sufficient details to support the diagnosis.

A person who is unable to work because of mental or physical disability or who is blind, and can provide medical evidence of his disability, can have his social security earnings record "frozen" under the new law.

The effect of this action is similar to that of the waiver of premium in life insurance policies. It provides that the benefit payable to the person when he qualifies, or to his family in case of his death, will not be reduced because of the period in which he had no earnings.

Persons already receiving monthly old-age insurance benefits, if they are disabled for a considerable period of time before they reach 65, may have their benefits increased under the new law beginning with payments for July, 1955.

The new law protects the social security records of people who have been in work covered by social security for 5 out of the 10 years before they were disabled, and for 1½ out of the 3 years before they were disabled; who are unable to engage in substantial gainful activity because of a medically determinable impairment which is expected to be of long-continued or indefinite duration; and who apply to have their records frozen while they are disabled and after they have been disabled 6 months or more.

The Social Security Administration hopes that many applicants can be returned to productive work through Vocational Rehabilitation services. Work in connection with rehabilitation services or in a "sheltered workshop" will not prevent a finding of current disability.

Suspend License of Dr. Fowzer

Madison, June 1.—The license of Lloyd R. Fowzer, M.D., Milwaukee, has been suspended for one year by the Wisconsin State Board of Medical Examiners. The action was based on his conviction of aiding and abetting the practice of medicine without a license.

The resolution adopted by the board on May 4, 1955, stated that "Lloyd R. Fowzer did on the 6th day of January, A.D., 1955, at that time being a duly licensed physician under the laws of the State of Wisconsin, aid, abet counsel and procure the commission of the offense of practicing medicine without license by one Harry E. Smith contrary to and in violation of Sections 353.05 and 147.14."

Smith was reported to have been practicing medicine for 18 months prior to January, 1955, part of that time in association with Dr. Fowzer. Smith is reported to have served a great many patients and prescribed drugs for them. He established his own office when his quarters with Dr. Fowzer became inadequate. Smith has neither a medical degree nor license.

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: Marvin D. Blackburn, Jr., M. D.

REPORT OF A CASE*

History: The patient was a 53-year-old, white, married female who was admitted to Bellin Memorial Hospital on September 15, 1954, with the complaints of "distress" across the upper abdomen and poor appetite and intermittent jaundice for the past two years.

Previously she had been perfectly healthy in her own estimation. She complained that pork, tea, and coffee aggravated her abdominal distress and caused intestinal gas. One year prior to admission she had had a gallbladder study done elsewhere, and it was reported as negative. Immediately prior to admission a gallbladder study showed the organ to be nonfunctioning, and stomach and colon fluoroscopic examination was negative. Her sedimentation rate was 26 mm. in one-half hour and 32 mm. in one hour (method unknown) prior to admission. In the year prior to admission she had lost 14 pounds. She stopped menstruating a year prior to admission and had had "hot flashes" and nervousness during that time.

Because of her lack of appetite she was given liver and B_{12} tablets and thought these caused her gaseous indigestion to become worse, but it persisted after she stopped the treatment.

Physical Examination: The patient was a well-developed but pale, thin, middle-aged, white woman. She weighed 90 pounds, her blood pressure was 140/86, pulse 96, respirations 16, and temperature 98.8 F. Her ears, eyes, nose, and throat were not remarkable. Her heart was of normal size; but a systolic gallop rhythm was noted with a short, rough, rublike sound at the apex. The abdominal wall was quite thin; and an irregularly shaped, movable mass was palpable in the region of the cecum and ascending colon. The right kidney was palpable but seemed to be separate from the mass, although the organ was present in the right flank. Pelvic examination was noncontributory, and the extremities were not remarkable.

Laboratory Studies: At the time of the patient's admission, the hemoglobin was 9.6 Gm.; the red blood cell count 3,300,000; and the white blood cell count 5,000 with 70 per cent polymorphonuclears, 28 per cent lymphocytes, and 2 per cent monocytes. The urine specific gravity was 1.008, pH 5.5. The urine contained an occasional white blood cell and red blood cell. Cephalin flocculation was negative in 48 hours after admission and the bromsulfalein test showed 50 per cent retention after 5 minutes and 20 per cent retention after 30 minutes. The stool was negative for occult blood on the day of admission and the sedimentation rate by the method of Westergren was 6 mm. in 10 minutes, 20 mm. in 20 minutes, 37 mm. in 30 minutes, and 75 mm. in 60 minutes.

Dr. M. D. Blackburn, Jr.: Doctor Killins, what is your impression of the differential diagnoses to be considered in this case?

Dr. J. A. Killins: This case represents an example of the patient who is passed from the internist to the surgeon with the comment, "Here is a nonfunctioning gallbladder which we had better explore." Everyone knows that she is not a typical case of chronic cholecystitis with stones. The presence of indigestion, a palpable mass in the upper abdomen, jaundice, and an elevated sedimentation rate all point toward a malignancy of some sort. The negative x-rays of the stomach and colon have presumably taken care of the two most common sites for a primary carcinoma which may have metastasized to the liver, but a metastatic carcinoma is still a likely possibility. The patient might be lucky enough to have a common duct stone, which offers her the best chance for a happy outcome. If she has a malignancy and if it is primary in the external biliary system, she probably can't be cured surgically but some palliative short-circuiting anastomosis between the gallbladder and the intestinal tract should give her real help for an indefinite time.

* From Bellin Memorial Hospital, Green Bay.

Chronic recurring pancreatitis could account for most of her symptoms, but the mass in the right abdomen makes this unlikely.

Doctor Blackburn: Do you think that any additional examinations will help us here?

Doctor Killins: A long series of diagnostic tests and further x-rays would add little to our knowledge, and at this stage an exploration of her upper abdomen should establish the diagnosis and offer us an opportunity to give her whatever surgical treatment seems advisable.

Hospital Course: The patient's condition remained stationary, and on the fifth hospital day her upper abdomen was explored and the following surgical note written: "The mass which was previously felt was found to be a corset lobe of the liver lying above a distended gallbladder. A biopsy was taken from the right lobe of liver and the gallbladder drained. The common duct was greatly distended; it was opened and probes passed through it into the duodenum. There was a definite obstruction which felt like tissue at the lower end of the common duct, and pieces of this tissue were removed. Also, a piece of tissue from the pancreas near the area of the common duct was removed. One Penrose drain was brought out of a stab wound to the left. The incision was closed in the usual manner."

Following surgery the patient failed to improve except for short periods, and her condition remained more or less static for the first five postoperative days. She complained of considerable incisional pain during the first 36 hours and was quite nauseated although vomiting was infrequent and of slight amount. The T tube drained bile intermittently; an attempt to put a Wangensteen tube in place was made, but the patient would not permit it and continued to pull it out. There was some belching, and a small amount of flatus was passed; but after the fifth postoperative day abdominal distention increased and became progressively more severe until death. The nausea increased greatly and the upper abdominal pain persisted, but vomiting remained very slight. The patient received 500 cc. of whole blood on the day after admission, on the seventh postoperative day, and on the ninth postoperative day; she also received 1,000 cc. of 5 per cent dextrose in normal saline on seven occasions. Dicrysticin, Demerol, Thorazine, and Prostigmin were administered during the postoperative period. Beginning on the fifth postoperative day the abdominal distention increased; the nausea became quite severe; and the patient refused everything by mouth except water, which she took in small amounts. She became progressively weaker and complained of severe upper abdominal pain and distention. On the morning of the tenth postoperative day she became restless and apprehensive, her pulse was weak and fast and her skin cool and clammy, she began to have mild convulsive movements of her entire body, and suddenly ceased breathing.

Dr. W. L. Bergwall: Doctor Killins, what did the biopsy tissues show?

Doctor Killins: The following descriptions of the biopsy material and diagnoses were rendered:

1. *Liver tissue*—Some infiltration of periportal areas by mononuclear-type inflammatory cells with minimal periportal fibrosis and proliferation of small bile ducts. *Diagnosis*—Periportal hepatitis with minimal periportal fibrosis. No evidence of cirrhosis.
2. *Pancreatic tissue*—Scattered, mononuclear-type inflammatory cells in interlobular location with a moderate degree of edema. *Diagnosis*—Low-grade chronic pancreatitis, nonspecific.
3. *Common bile duct tissue*—Tall, columnar, malignant neoplastic cells in islands, secondary in this location and fairly well differentiated. *Diagnosis*—Carcinoma, secondary, arising either from the bile duct or possibly from the ampulla of Vater.

Doctor Blackburn: Only the principal findings at postmortem are given.

Considerable foul-smelling gas and a small amount of greenish fluid were present in the peritoneal cavity. The right pleural cavity contained approximately 150 cc. of light reddish-brown, thin fluid, while the left pleural cavity contained approximately 500 cc. of greyish-brown, rather thick fluid which had the odor of gastric contents and in which finely divided, whitish particulate matter floated. The fluid in the left pleural cavity compressed the lower lobe of the left lung; but, except for beginning hypostatic pneumonia in each lower lobe, the lungs were not otherwise remarkable.

The cardiovascular system, spleen, and pancreas were not particularly remarkable except for some induration about the head of

the latter. Except for a moderate degree of ptosis of the right kidney, the adrenal glands and urinary tract were not particularly remarkable. The internal genital organs were atrophic in appearance.

Dissection of the esophagus revealed a rather marked congestion and focal hemorrhage of the mucosa along with a ragged-margined perforation approximately 4.8 cm. proximal to the cardiac end of the stomach. This perforation measured 1.1 cm. across. The gastric mucosa was somewhat congested but not otherwise remarkable. On opening the duodenum, a malignant neoplasm was seen in its second portion surrounding the ampulla of Vater. This neoplasm measured as much as 3.1 cm. across and had rolled margins. There was no evidence of ulceration on its surface. The common bile duct was rather rigid in its terminal portion, but the liver was not remarkable except for congestion.

Microscopic examination revealed the neoplasm to be rather well differentiated and derived from the mucosa of the ampulla. The cells composing it were tall, columnar, and of bile duct type. The neoplastic cells extended for a short distance into the common bile duct wall and invaded the peripancreatic tissues about the head. The ulcerated area in the lower esophagus had necrotic borders, but the etiology of this process was not disclosed in the sections although it may well be of the so-called peptic variety. There was no demonstrable dilatation of the veins of the distal esophagus. The diagnoses made on the biopsy tissues from the liver and pancreas were confirmed on microscopic examination of these organs, as was the gross impression of an early hypostatic pneumonia.

This patient showed the effects usually seen in primary carcinoma of the ampulla of Vater; namely, obstruction of the outlet of the common bile duct and Wirsung's duct into the duodenum, with regurgitation of bile into the biliary radicles and consequent jaundice as well as edema of pancreatic tissue. These carcinomas rarely extend very far into adjacent tissues, and the picture seen in this patient is about the limit of extension seen in carcinomas arising in the ampulla of Vater. The etiology of the ulceration and perforation of the lower end of the esophagus was not disclosed.

Doctor Blackburn: Doctor Edelblute, do you feel that these lesions are diagnosable radiographically and, if so, how frequently?

Dr. L. H. Edelblute: Since this lesion was reported only approximately 3 cm. in diameter at postmortem examination, it is quite possible that a month previously it would have been imperceptible in the mucosal pattern of the descending portion of the duodenum. As to the method of finding these lesions, the standard barium examination of the upper gastrointestinal tract probably is and will remain the best. Special studies have been suggested, including air contrast studies and special positioning where disease in this area is suspected. Probably we would do well to use these special positions when examining the upper gastrointestinal tract in any patient who is clinically jaundiced. As for the findings themselves, whatever refinements are used, they remain two in number. The first of these is a filling defect which, as has already been stated, may be very small in a small ampullary neoplasm; the second is a distortion or destruction of the normal mucosal pattern of the descending portion of the duodenum. This latter finding must, of course, be a constant one. Any number of films showing distortion of the mucosal pattern are negated by a single projection showing a normal mucosal pattern, and thus indicating that the others did not show a true deformity but the result of a physiologic contraction. At any rate, I don't think we should be overly critical of the fluoroscopist who did not see this lesion; there may well have been nothing perceptible. I think this case points up the necessity for us fluoroscopists to regard the second portion of the duodenum with a high index of suspicion, particularly in the jaundiced patient.

Summary

A case of carcinoma primary in the ampulla of Vater has been reported. The patient showed the usual features of this disease with the one exception of the unusually interesting method of her demise; namely, ulceration and perforation of the lower end of the esophagus with hydrothorax due to gastric contents regurgitating into the left pleural cavity. Complication of ampullary carcinoma by ulceration and perforation of the esophagus or coexistence of these two lesions has not been previously encountered by the reporter.

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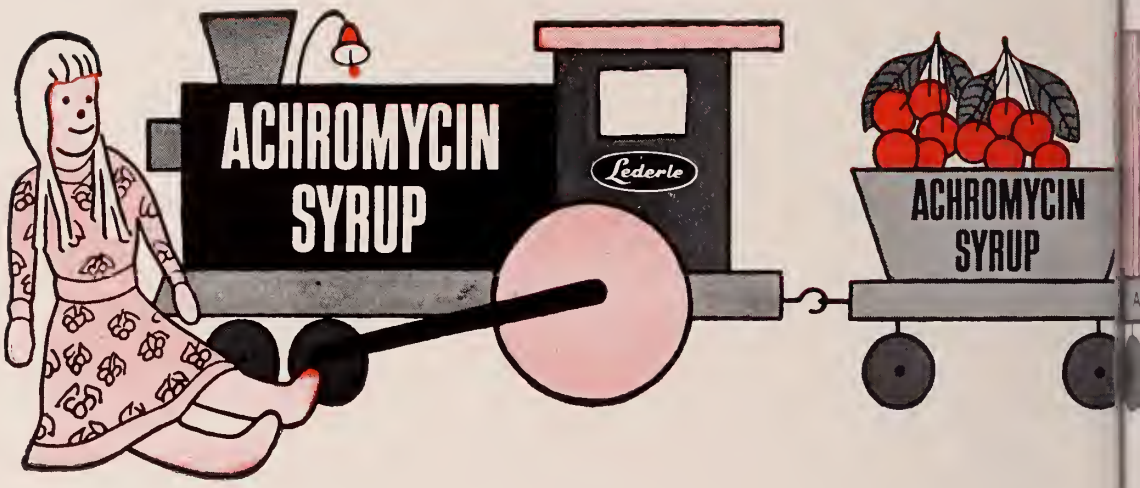

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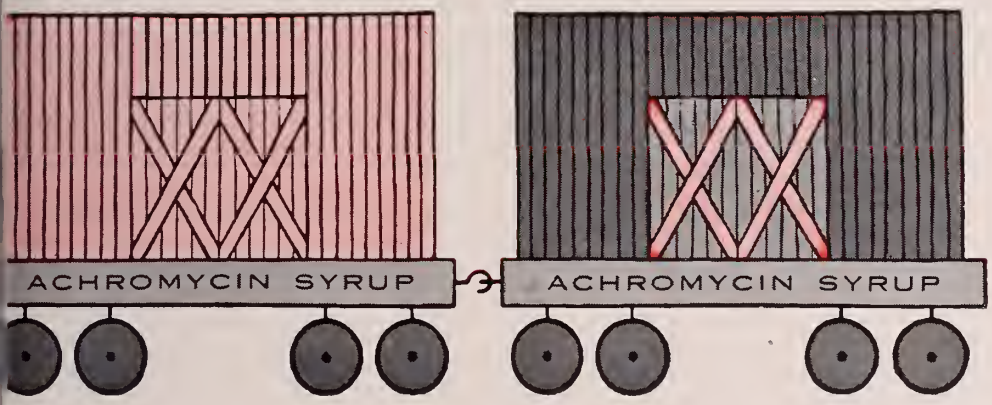

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Modern Management and Treatment of Ureteral Calculi

By SIDNEY P. HURWITZ, M. D., EDWARD B. JACOBSON, M. D., and ISADORE I. KOLMAN, M. D.

Milwaukee

Introduction

THE method used in the diagnosis of ureteral calculi may have a direct effect on the clinical course of the patient.

This presentation deals with a plan for atraumatic diagnosis of ureteral calculi and their management. The method has resulted in a low morbidity, devoid of many usual, accepted complications, reduced hospital stay, and an early return to work for the patient. Of secondary importance, but of some consideration, has been the low incidence of anxiety and an increase in restful hours for the attending urologist.

A calculus which lodges in, or eventually passes down the ureter, is a common urological entity. Symptoms may be minimal but in most cases are explosive and characterized by severe pain in the abdomen, radiating to the flank and at times to the testicle. Nausea, vomiting, and microscopic or gross hematuria frequently are present. Pyuria and fever occur with associated infection.

Because of the acuteness of the disease, the patient is usually seen first by his family physician, and shortly thereafter the burden of management falls upon the urologist. From there on, the clinical progress may be relatively benign or wrought with sequelae and complications.

Diagnosis

The management of the patient must begin with an accurate diagnosis. It is here that the utmost acute judgment must be exercised. This does not begin with the reading of the x-ray films but with the manner in which they are obtained. The procedure employed should be entirely atraumatic, if possible.

In every case, after a plain x-ray of the kidneys, ureters, and bladder is made and a shadow seen indicating the possible presence of a calculus, an intravenous urogram should be obtained. In the majority of patients, no preparation is necessary since they are usually poorly hydrated as a result of vomiting.

The intravenous urogram will usually lead to an accurate diagnosis of a calculus in the ureter and at the same time give information on the status of the urinary tract on the opposite side. In many patients, there will be no evidence of function, or only evidence of dilatation of the calyces on the affected side. However, *delayed upright* films, taken 1, 2, 4, and at times as long as 24 hours later, will frequently show contrast media filling the upper urinary tract down to the level of the calculus (Figs. 1 and 2).

To be hasty with the cystoscope *in making the diagnosis* may compound a simple case to one with many complications and change the entire course of events in the following ways:

1. The passage of a catheter beyond the calculus and the injection of contrast media, no matter how careful the technic, may introduce infection above the obstruction and create a pyelonephritis or pyonephrosis.

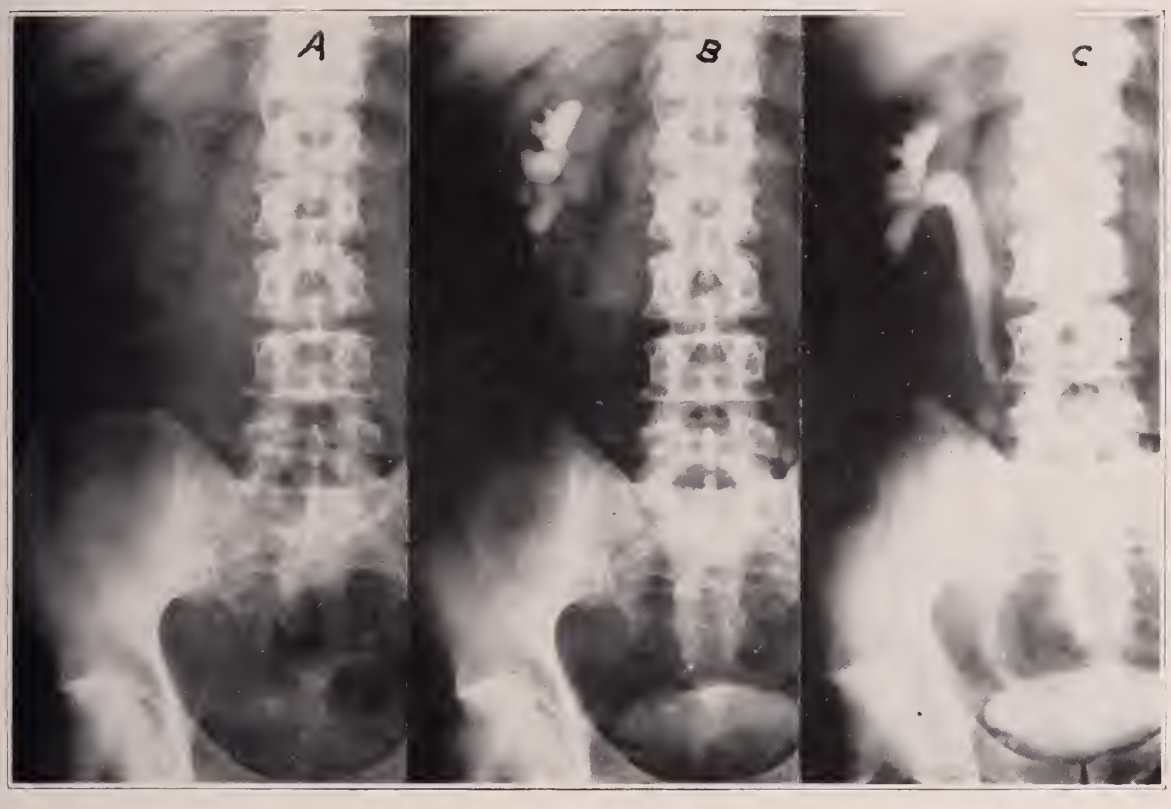
2. The catheter may alter the position of a calculus, changing an incomplete to a complete block, and produce a much more clinically ill patient.

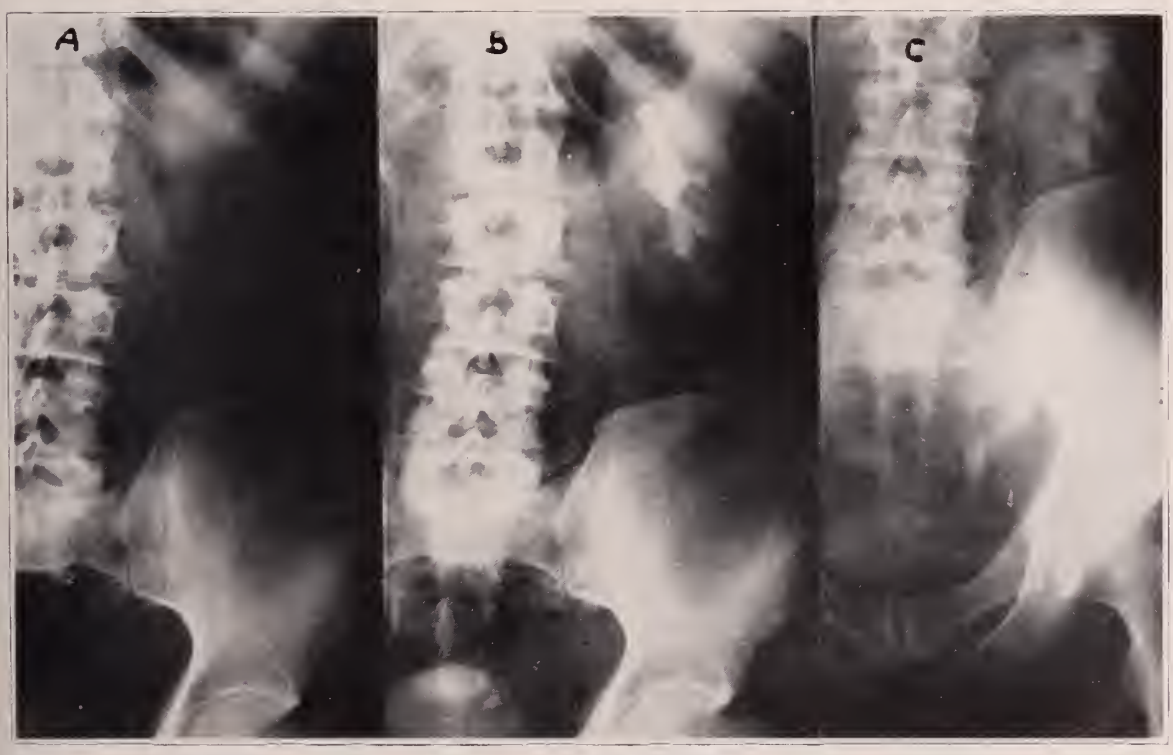
3. In many patients subjected to cystoscopy, a complicating acute posterior urethritis and prostatitis may develop, making it difficult to evaluate precisely the primary condition.

4. Perforation of the ureter may occur during the course of diagnosis.

We do not wish to imply that cystoscopy should never be employed in the diagnosis of ureteral calculi. It should be reserved for the occasional cases with radiolucent calculi, those which cannot be diagnosed with intravenous urograms, or when the intravenous injection of contrast media is contraindicated (Figs. 3 and 4).

Having made the diagnosis of an ureteral calculus *atraumatically* with intravenous urograms, one now has *time* to evaluate the patient.





Figs. 1a and 2a—KUB. Radiopaque shadow in region of terminal ureter.
1b and 2b—Final film of routine intravenous urogram series. No visualization of contrast media in ureter.
1c and 2c—Delayed upright film revealing contrast media filling ureter down to calculus.

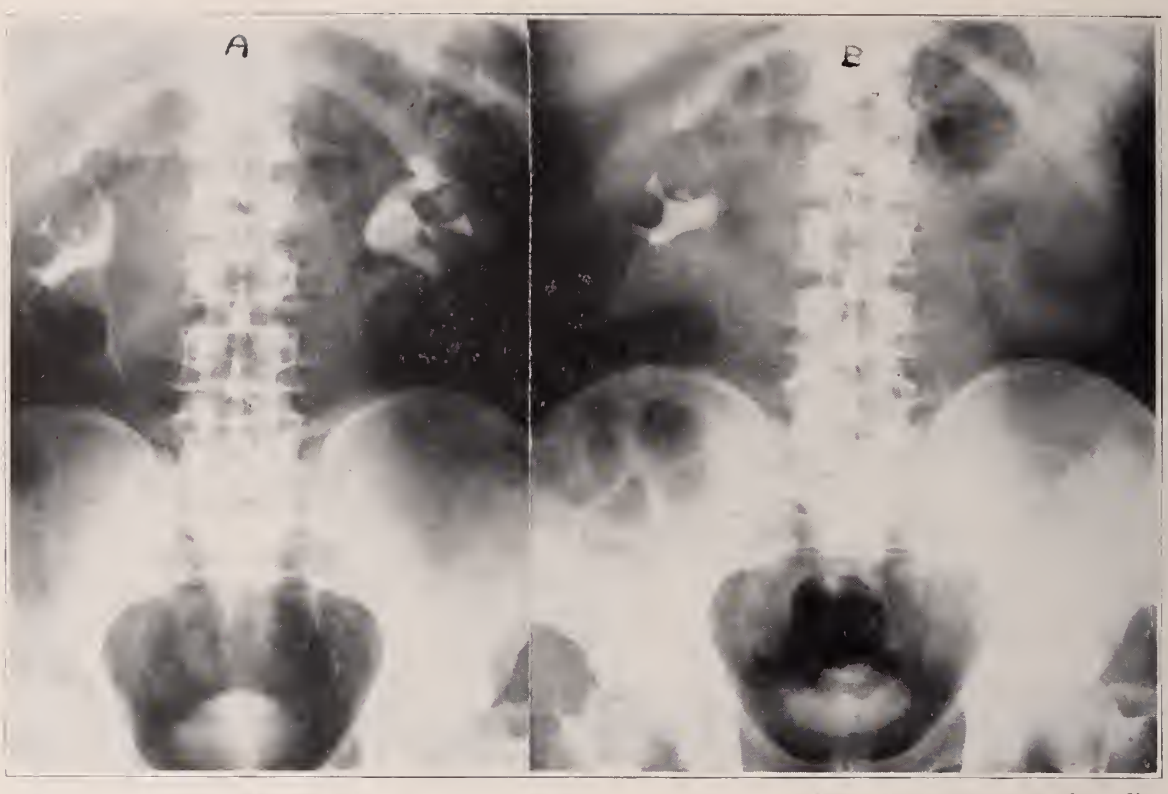


Fig. 3a—Patient with gout. Previously passed large uric acid calculi. Intravenous urogram reveals radiolucent shadow in left renal pelvis.

3b—Three months later, mild left renal and ureteral colic. Complete loss of renal function radiographically. Intravenous urogram of no aid in diagnosing calculus in ureter.

Management

Our decision to intervene or follow a conservative course of watchful waiting is influenced by several factors; namely,

1. Anuria
2. Pain
3. Chills and fever
4. Toxicity
5. Size of calculus
6. Position of calculus
7. Patient's previous experience with ureteral calculi

Anuria. This condition, due to calculi producing bilateral ureteral obstruction, or obstructing a solitary ureter, is an indication for immediate intervention. This can be performed through a cystoscopic or open surgical procedure, depending upon the various factors present (Figs. 5 and 6).

Pain. Pain may be controlled with narcotics and antispasmodics in most cases. Individuals in whom the pain is constant and uncontrollable require intervention.

Chills and Fever. These symptoms are an indication of infection above the obstruction. Urinary tract antibiotics should be used; however, if the chills and fever persist, drainage is indicated. Rising white blood cell counts in the face of low-grade fever are a sign of pyelonephritis or beginning cortical abscesses.

Toxicity. Persistent nausea and vomiting and reflex ileus, although controllable by parenteral fluids and stomach and intestinal tubes, are spontaneously relieved by the removal of the obstruction.

Size of Calculus. Calculi smaller than ½ cm. in diameter will pass in the vast majority of cases. Those between ½ and 1 cm. in diameter may or may not pass spontaneously. Calculi 1 cm. in diameter or larger usually will not pass. Patients with calculi larger than 1 cm. in diameter will do better clinically without manipulation and with open surgery.

Position of Calculus. Any calculus lying above the lower third of the ureter should not be manipulated. The incidence of complications resulting from manipulation of

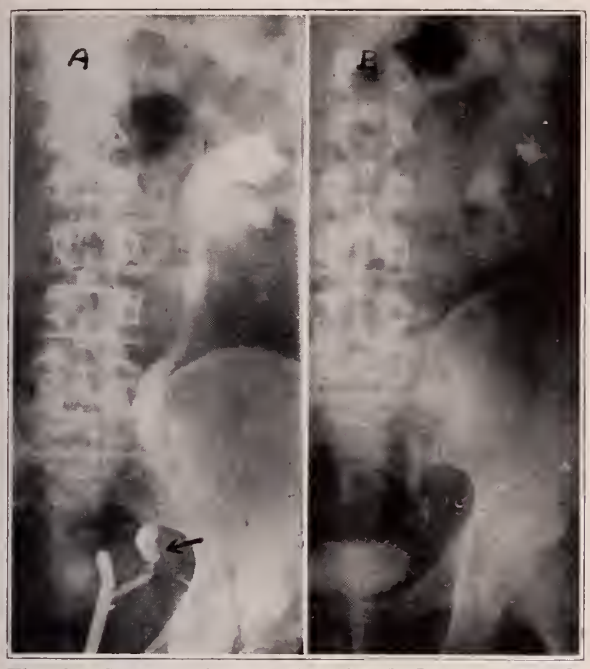


Fig. 4a—Same patient as in Fig. 3. Left retrograde pyeloureterogram localized radiolucent calculus in lower third of left ureter. Patient treated conservatively in view of past history. Calculus passed spontaneously four days later.

4b—Follow-up intravenous urogram reveals return to normal.

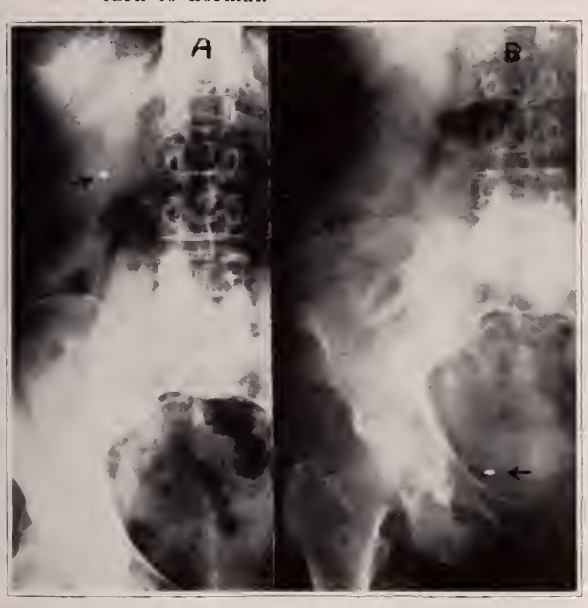


Fig. 5a—Asymptomatic calculus in solitary right kidney. Left kidney previously removed.

5b—Mild right renal and ureteral colic. Previously noted calculus now in terminal portion of right ureter.

high ureteral calculi is great. One may wait for a high ureteral calculus less than 1 cm. in diameter to pass to the lower third and then manipulate, if indicated. A calculus 1 cm. in diameter or larger which is ob-

Fig. 6—Same patient as in Fig. 5. Intravenous urogram reveals grade I dilatation of right upper urinary tract. Contrast media fills entire upper urinary tract down to calculus. Treated expectantly in spite of potential anuria. Passed calculus spontaneously.

served to pass slowly down the ureter should be intercepted by open ureterolithotomy before it descends to the lower third. This may seem like radical management in a patient with a moving calculus; however, we feel that we are intercepting a bomber before it drops its bombs.

Patient's Previous Experience with Ureteral Calculi. All of us have encountered patients with acute renal and ureteral colic who gave a history of having passed several calculi at irregular intervals during their lifetime. Some patients may even display a box containing many calculi, large and small, that they have expelled. One must definitely respect this past experience and therefore choose a conservative route of management, whether the calculus at hand is high or low, smaller or larger than 1 cm. in diameter.

A more radical approach will be indicated only with the development of uncontrollable complications.

If intervention becomes necessary, one must decide whether manipulation or open surgery is the procedure of choice. The deci-

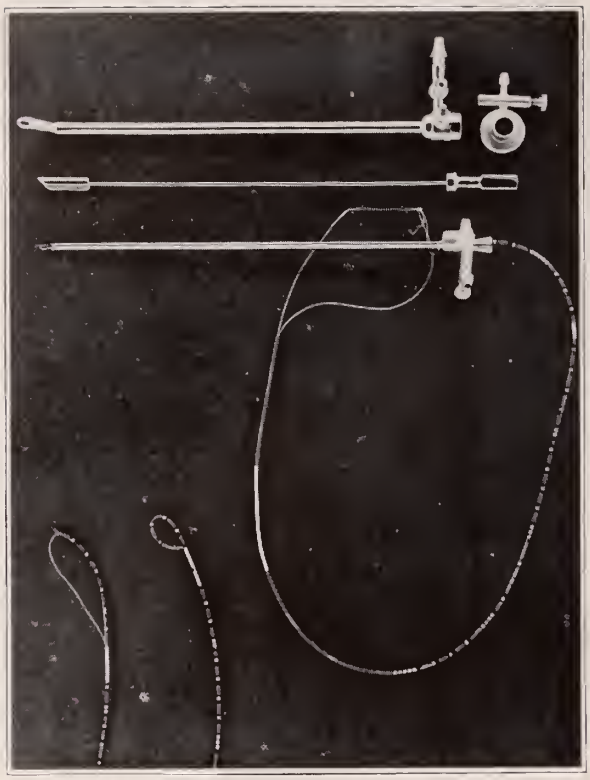


Fig. 7—Double-barrel Braasch cystoscope.

sion will depend upon the various criteria mentioned.

If it is decided to extract the calculus cystoscopically, the patient is given morphine and atropine, and 1,000 cc. of 10 per cent dextrose in water, 1½ hours preoperatively. The latter will create a pressure head above the ureteral calculus and will possibly increase the dilatation above the site of the block. The patient is then taken to the operating room and given a spinal anesthetic. We prefer this type of anesthesia because it relieves spasm of the ureter and ureteral orifice. This allows for easy insertion of the extracting instrument beyond the calculus in most cases. Not too infrequently, the combination of a preoperative pressure head and the spinal anesthesia will produce a spontaneous extrusion of a small calculus into the bladder.

The ureteral calculus extractor used should be one which has given the highest percentage of extraction for the particular surgeon performing the procedure. We prefer the loop catheter since it easily by-passes the calculus without displacing it to a higher

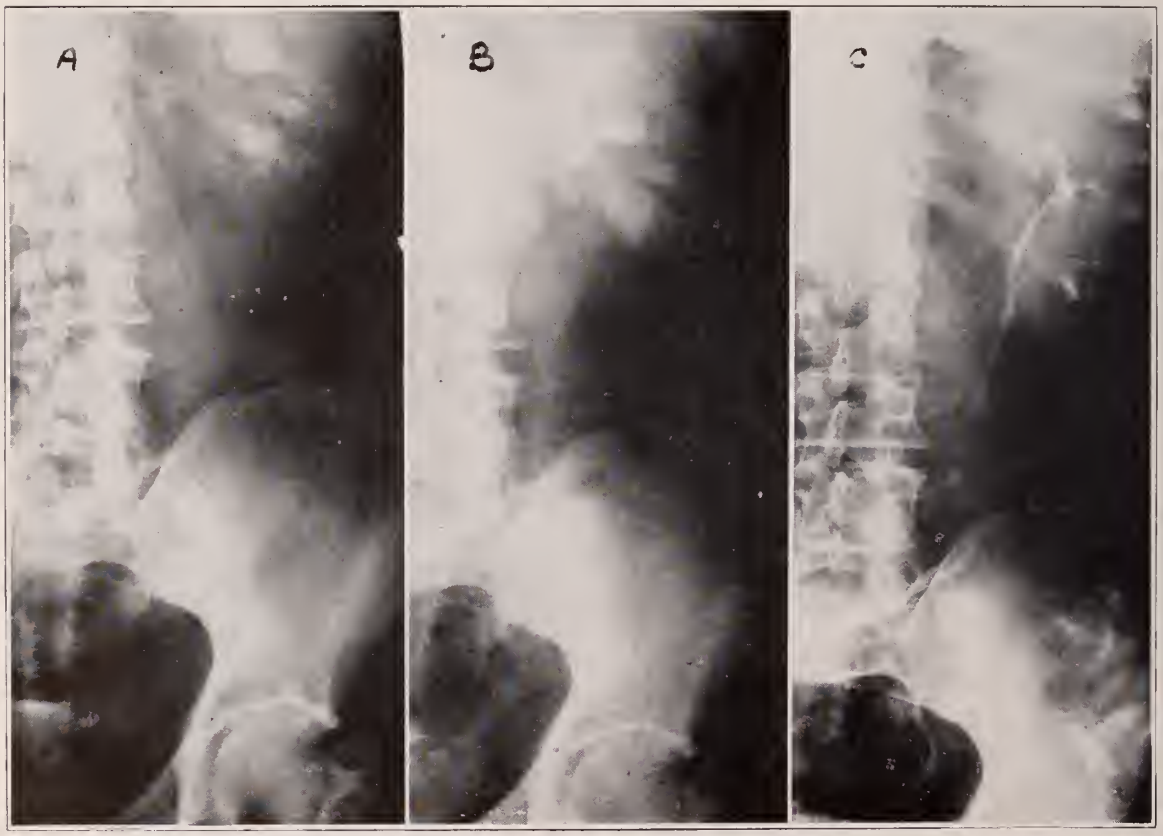


Fig. 8a—Large radiopaque shadow in region of terminal portion of left ureter.
8b—Intravenous urogram. Delayed upright film. Contrast media fills ureter down to calculus. Calculus extracted with aid of ureteral meatotomy after engagement in loop catheter.
8c—Intravenous urogram six weeks later reveals return to normal.

level. Injury to the ureter is negligible. Should the loop and calculus become impacted in the ureter, the loop can easily be removed by releasing the tension on the silkworm thread.

We prefer the double-barrel Braasch cystoscope. The barrel guides are complete down to the distal end of the sheath. One barrel is used for the loop catheter, which can easily be passed beyond the calculus without buckling. The other barrel is used for a cutting electrode, permitting an ureteral meatotomy if necessary, without changing cystoscopes, and with the calculus already engaged in the loop (Fig. 7).

Once the calculus is engaged, at no time should there be any undue tension on the extractor. We usually place 2 to 4 pounds of tension on the extractor for about one minute and then take all tension off for about one-half minute. This is repeated several times and allows the intramural portion of the ureter to dilate much like the cervical os in active labor.

If the calculus cannot be extracted with this procedure plus an ureteral meatotomy, the patient should be returned to his room with the extractor in place. Tension placed on the extractor at regular intervals thereafter will usually produce the calculus after several hours or days (Fig. 8).

Prior to manipulation of an ureteral calculus, the patient or his family should be informed that a calculated risk is present. Should the calculus not be recovered, complications may develop which could require emergency open surgery.

With the use of the loop catheter and Braasch cystoscope, we have experienced a high recovery of lower ureteral calculi that required intervention.

If open surgery is indicated, the type of approach used is dependent upon the location of the calculus.

Calculi impacted in the ureter between the ureteropelvic junction and the level of the lower pole of the kidney are removed through an oblique flank incision like that used in nephrectomy. The lower pole of the kidney is freed and retracted medially and anteriorly. The remainder of the kidney need not be disturbed (Fig. 9).

Calculi trapped between the lower pole of the kidney and the level of the iliac crest are easily removed through the lumbar route as described by Foley. This portion of the ureter is very adequately exposed through a small oblique linear incision without cutting muscles. Closure of the wound is simple, requiring three or four sutures in the fascia. The convalescence is rapid, most patients being ready to leave the hospital on the fourth or fifth postoperative day (Fig. 10).

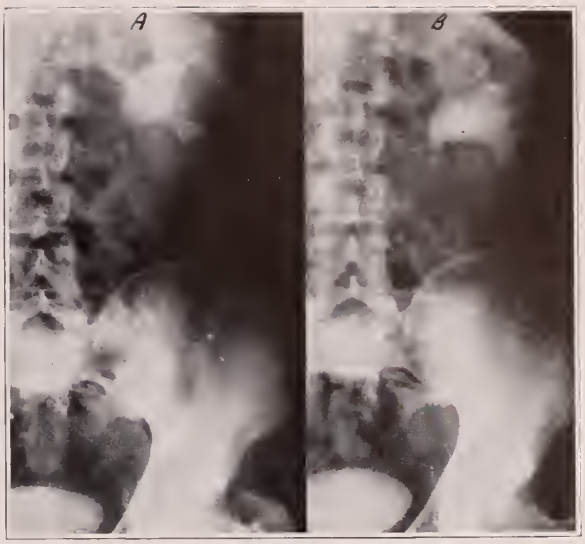


Fig. 9.

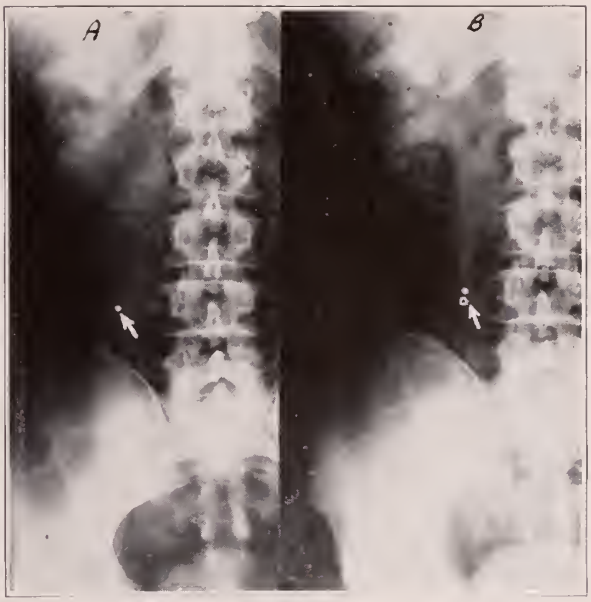


Fig. 10.

Calculi which have become arrested in the region of the sacroiliac synchondrosis are removed through a McBurney muscle-splitting incision with the patient lying on his back. Here again, the ureter is adequately exposed retroperitoneally and the calculus easily removed. Convalescence is short with very little discomfort (Fig. 11).

Fig. 11.

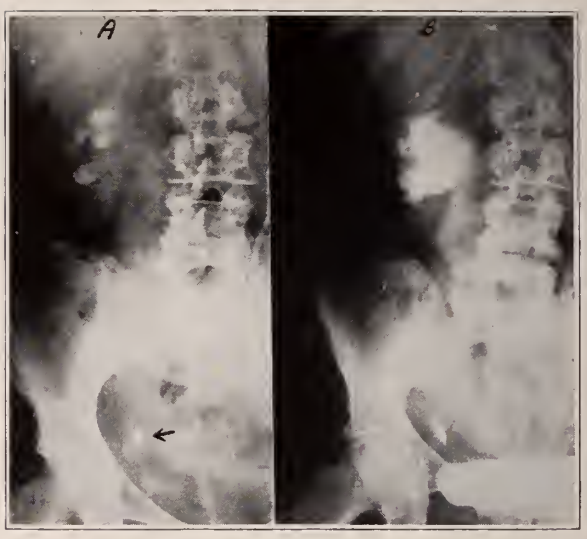


Fig. 12.

Calculi which lie in the lower third of the ureter below the level of the sacroiliac synchondrosis are removed through a Gibson incision. Here wider exposure is necessary because of the depth at which the ureter is located. Not too infrequently it is necessary to ligate and sever the inferior epigastric vessels and the vas deferens in order to gain adequate exposure (Fig. 12).

Following the removal of the calculus, an attempt is always made to pass a No. 8 ureteral bulb down the ureter through the ureterotomy opening to determine patency.

All patients in whom urinary-tract calculi form should have blood calcium, phosphorus, uric acid, and total protein determinations. Twenty-four hour calcium excretion determinations of the urine are ordered whenever indicated. Urine cultures are always obtained to determine the presence or absence of infection. All calculi removed are chemically analyzed. With this data on hand, one is better able to determine the underlying cause for the calculus formation and to outline a course of therapy to decrease the possibility of recurrence.

Summary

A plan for atraumatic diagnosis of ureteral calculi has been presented.

Intravenous urography, with delayed and upright films, should constitute the initial diagnostic procedure. Cystoscopic diagnosis should be reserved for the occasional cases with radiolucent calculi, those which cannot be diagnosed with intravenous urograms, or when the intravenous injection of contrast media is contraindicated.

The indications for management via conservative, manipulative, and operative routes have been discussed. Conservatism is urged whenever possible.

Cystoscopic extraction or manipulation of an ureteral calculus is not an innocuous procedure. Complications may develop which could require emergency surgery. Extraction should be limited to calculi in the lower third of the ureter and should be done only when definite indications are present.

Studies necessary to help prevent recurrences are outlined.

(S.P.H.) 606 West Wisconsin Avenue.

EXHIBIT SPACE AVAILABLE AT WAGP MEETING

Scientific exhibits will be included as a part of the Wisconsin Academy of General Practice scientific assembly at the Milwaukee Auditorium, September 26 and 27.

A limited number of booths will be provided free of charge to physicians or organizations who have worth-while displays to present.

Anyone interested in obtaining a booth is encouraged to apply to:

Robert F. Purtell, M. D., Secretary
Wisconsin Academy of General Practice
758 North 27th Street
Milwaukee 8, Wisconsin

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

COMPLICATIONS OF ANTIBIOTIC THERAPY

In previous numbers of this Journal, the undersigned presented some remarks relative to the liabilities resulting from the uses of antibiotics. As time passes and more and more evidence accumulates relative to both the good and the bad, again I feel the advisability of continuing the warning. This was prompted by an authoritative article by W. F. von Oettingen,[1] who, like the writer of these "Comments," is primarily a pharmacologist and is privileged to sit on the sidelines and cheer or moan, as required by successes and tragedies following clinical uses and abuses of antibiotics. It is recognized that the physician is apt to get the blame if a patient dies because of the antibiotic treatment employed, or even because of nonuse of one or another or even several of the "miracle" drugs requested by the patient or his relatives.

There are many liabilities associated with these and, one might add, most drugs. Among the various dangers is that of sensitization, which reaction may cause an anaphylactic shock, with a mortality rate reported to be approximately 50 per cent. These allergic reactions are about five times as likely in those who have had previous antibiotic medication, chiefly penicillin, as in those who have never been previously subjected to, hence sensitized to, the drug. Other antibiotics receive less blame than penicillin, probably because they are far less commonly employed. Give them time, and one may expect them to rival penicillin in that respect.

Skin reactions to penicillin are on the increase, due in part to widespread and injudicious uses. Urticarial eruptions, angioneurotic edema, and fixed drug eruptions may and do occur in some of the patients after repeated application of antibiotics, and especially in those individuals who are allergic. Rhinitis, conjunctivitis, and bronchial asthma have appeared after use of penicillin probably more frequently than after use of other antibiotics, evidently because it is by far the most popular, most commonly used, and generally the safest yet available. Drug fever and serum sickness type of reactions occur. Aplastic anemia is reported to have occurred after the use of chloramphenicol. Evidently this particular drug should not be used for prolonged administration or for repeated courses. These adverse reactions have rarely occurred as a result of the first course of treatment but mostly after subsequent administrations.

Eosinophilia has been observed following prolonged administration of penicillin and of streptomycin. Extensive hemorrhages and gangrenous ulcerations leading to death occurred after a second course of penicillin in an infant. Hypersensitization through inhalation of fungal spores has been suggested as a cause of reactions when corresponding types of antibiotics are employed. Overgrowth of yeasts and fungi in the intestinal tract has been observed and is ascribed to a disturbance in the intestinal flora which upsets the balance between fungal organisms and bacteria, the latter being far the most susceptible to the more commonly employed antibiotics. However, staphylococci rather readily become relatively resistant to antibiotics, which condition may lead to an uncontrollable overgrowth of these micrococci with the known possibility of a resultant systemic intoxication.

Finally, as we have very likely mentioned in previous "Comments," drugs of most categories should be considered as emergency aids and should not be employed without clear-cut indications, comparable to major or minor surgical operations. To use an antibiotic, or most any other drug for that matter, as a prophylactic, "just in case," and without real indications, would not seem to be reasonably indicated in view of the possible serious consequences which might follow.—A. L. TATUM, M. D.

REFERENCE

1. von Oettingen, W. F.: Complications of antibiotic therapy, Am. J. Med. 18:792–809 (May) 1955.

Many Laboratories Now Approved

As It Looks to Your State Board of Health

THE program for the approval of laboratories provided by the 1951 state legislature has been in operation in Wisconsin for nearly four years. To date the State Board of Health has included only public health examinations for water and milk on the list of laboratory procedures to be evaluated. However, the law is broad enough to provide for the evaluation of the majority of laboratory examinations of public health significance. Additional procedures may be included in the future by action of the State Board of Health.

Currently, a total of 67 laboratories are approved for one or more examinations for water or milk. Of this number, 9 are approved for water tests only.

After an evaluation is requested, the laboratory is visited for the purpose of determining its conformity with "Standard Methods." Equipment, quarters, and the technic of the laboratory personnel are evaluated. Also, the results of split-samples are taken into consideration in evaluating the performance of participating laboratories. A reevaluation is made annually, and the performance of the laboratories making milk examinations is checked with the split-sample procedure every six months.

The shipment of split-samples appears to be an effective way to determine the efficiency of participating laboratories. Five major shipments have been made to approved laboratories or laboratories requesting approval. The results have shown considerable improvement over the past two and one-half years.

The standard bacterial plate count for milk is one of the methods that has been checked by the split-sample procedure. (The standard plate count gives an indication of the general sanitary conditions under which the milk has been processed and stored). A total of 722 standard plate count reports suitable for comparative purposes have been tabulated. Sixty-seven per cent (485 out of 722) have shown agreement in the acceptable range, *i.e.* $\mp$ 20 per cent of the arithmetic average. However, 79 per cent of the results of the most recent shipment fell within the desirable range.

Another interesting observation in regard to the last split-sample shipment was this: two of the samples of this shipment were artificially contaminated with a culture of bacteria which were isolated from pasteurized milk and which are sensitive to incubator temperatures of about 35 C. Many pasteurized milk samples contain bacteria of this type. These bacteria produced colonies on plate-count agar when incubated at 35 C. for 48 hours (standard conditions for the test). However, at an incubator temperature slightly over 35 C. visible colonies are not produced. Only 53 per cent (31 out of 58) of the results on these two samples were within the desirable range of agreement.

The remaining samples of this shipment were low-count samples and samples that were artificially contaminated with bacteria that were more tolerant to small elevations of incubator temperature. Eighty-seven and one-half per cent (148 out of 169) of these results fell within the desirable range.

The above observations together with information gathered on the follow-up visits to laboratories reporting anomalous results stress the importance of carefully controlled incubator temperatures in obtaining accurate standard plate counts on market milk.

The annual refresher courses at the State Laboratory of Hygiene have been of value in improving the standard of performance in making milk examinations. These five-day courses provide an opportunity for laboratory personnel to discuss and to hear discussed the theory and practice of "Standard Methods" procedures. The laboratory sessions give them an opportunity to learn by the actual performance of the various tests under the guidance of qualified instructors.
—D. I. THOMPSON, *Director of Laboratory Certification.*

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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Volume 54 JULY 1955 Number 7

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Advertising Representative: State Journal Advertising Bureau of the American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

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A Statement Is Due

"A clear and concise statement" of why the American Medical Association is opposed to compulsory inclusion of physicians under the Federal Old Age Survivors Insurance program is to be drafted by the A.M.A. Board of Trustees for circulation to the medical profession and the public. Such a statement is overdue.

True, the A.M.A. has long distributed its opinions of so-called social insurance programs. While some of these have been complicated and verbose, the nation's social security laws are, after all, amazingly baffling. All the more reason for some clear explanation of the A.M.A.'s position.

From the practical standpoint, the A.M.A. has not fared too well in its efforts to arrange tax-deferred pension programs for the nation's physicians. As a result, the young physician about to enter practice who has a family and the elderly physician who has been unable to establish a personal pension program look with a longing eye at the survivor and retirement aspects of the federal program. Philosophically, it might also be said that physicians might be in a better position to correct an admittedly confusing social security system if they were critical participants rather than condemning holdouts.

Recent news reports indicate that the House Ways and Means Committee has used its Democratic majority to draft a liberalization of the Social Security System behind closed doors. Chairman Cooper has said a motion to include physicians was rejected because "the information we have obtained is that they don't want to be included." There was no mention of leaving it to individual physicians to voluntarily come under the program if they so desired. Apparently only compulsion will satisfy those drafting the bill.

In any event, the question of whether physicians should be included in OASI programs voluntarily, compulsorily, or not at all is something of a mystery to many physicians and the public alike. The reason is plain. Our social security system is so complicated it almost defies reasonable interpretation and consideration. The result is that the physician's understandable indecision is used to make political and publicity "hay."

Yes, now is the time for the A.M.A. to come to the aid of its members with a clear and concise statement on social security.

A Real Service to Doctors

You might think that choosing a place to practice medicine is a simple task these days. Not quite so. Despite the fact that some 100 Wisconsin communities are seeking physicians, the task of selecting a location that will supply professional challenge, offer adequate facilities for medical practice, and meet

personal and family desires is an imposing one. It is no problem to learn the names of towns where physicians are desired, but it is quite another matter to visit each place to ascertain the opportunity it offers.

As every Wisconsin medical student and hundreds of practicing physicians know, some excellent assistance is provided through the physician placement service of the State Medical Society. The Society maintains close contact with communities seeking physicians or with physicians seeking associates. By means of lengthy questionnaires, the Society learns those things about each community which will be of most value to physicians who must make a choice. This information is condensed and sent to every physician known to be seeking a location. The detailed information available in these reports permits him to do a significant amount of screening before making personal visits to the communities which might be his first choice.

Currently, the Society lists 74 general practitioners and 133 specialists as seeking locations in Wisconsin. During the past year, this service has been of direct assistance to more than 40 physicians who eventually located in the state. It has undoubtedly been of indirect assistance to a similar number.

Equally as important as the service provided the doctors is the aid the Society's program brings to small communities who need resident medical service. Here are some of the communities whose medical needs have been helped during the past year: Tigerton, Hillsboro, Granton, Eagle River, Burlington, Cambridge, Waterloo, Chetek, West Salem, New Richmond, Park Falls, Richland Center, Cedarburg, Endeavor, and Sturtevant.

Add to these many bigger cities whose physicians have obtained associates or which have new physicians in individual practice, and it is apparent that the Society is performing a continuing and important service to both physicians and the communities of the state.

Hark the Medical Student

The Blue Shield bulletin in this issue (page 33) is composed of excerpts from an essay by a Wisconsin medical student. The essay was his entry in a recent contest sponsored jointly by the Student American Medical Association and the national Blue Shield Commission. Physicians who are interested in the role of socioeconomic matters and the impact of insurance on the practice of medicine will do well to consider his remarks rather thoughtfully.

They might, for example, wonder:

Is the development of an appreciation for the value of early diagnosis and treatment of disease one of the functions of Blue Shield? Should it be? Can it be? Is Blue Shield an investment which should be expected to provide "just returns"? Are these expressions of a philosophy of medical economics being taught in medical schools? What kind of education should the medical student receive in regard to the social and economic function of the practicing physician?

Memo to HEW

Madam Secretary: Please note an Associated Press story out of Los Angeles dated July 11:

"Household pets now can be enrolled in a prepaid medical care program in Los Angeles involving 20 affiliated veterinary clinics. Known as the pet health plan, it covers hospital care as well as medical and surgical treatment for dogs and cats . . . The cost is $20 a year . . . The corporation is building a hospital . . . which will include a closed circuit television installation to permit the staff to witness difficult surgical operations and other advanced treatment procedures so as to maintain progress."

Don't you think that the Department of Health, Education, and Welfare would promote "progress" even more if it offered a bill to Congress for animal health reinsurance on such ventures?

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION

The 33rd annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held August 28 to September 2 at the Hotel Statler, Detroit.

Scientific and clinical sessions will be given August 29, 30, 31, and September 1 and 2. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, annual instruction seminars will be held.

Full information may be obtained by writing to the executive secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

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Notes on the Diagnosis and Management of "Dizziness"

II. False Dizziness

1. Romberg's Sign

The patient stands with his feet together and his eyes closed. Inability to maintain equilibrium may indicate locomotor ataxia or sclerosis of the posterior columns of the spinal cord (tabes dorsalis).

2. Inability to Walk a Straight Line

3. Inability to Stand on One Foot

A patient's inability to stand on one foot without lurching may be a helpful test in distinguishing between "dizziness" which is purely psychogenic and that which is of organic origin.

False dizziness is a sensation of sinking or lightheadedness which is often of psychogenic origin. It should be distinguished from true "dizziness" or vertigo[1] in which there is a definite whirling, moving sensation.

Unsteadiness, lightheadedness and similar manifestations of false dizziness[2] may be psychogenic or the result of arteriosclerosis, hypoglycemia, drug sensitivity and general metabolic disturbances such as anemia and malnutrition. Hypertension is often the cause of these symptoms.

Psychogenic dizziness probably originates at the highest brain centers. It may be described as a sense of uncertainty with occasional mild lurching but not to the point of falling. In these patients there is no nausea, no disturbance of vestibular pathways and otologic and neurologic examinations are negative. The sensation is unaffected by head movement. Symptoms usually disappear[3] with complete rest.

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1. Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.
2. DeWeese, D. D.: Symposium: Medical Management of Dizziness. The Importance of Accurate Diagnosis, Tr. Am. Acad. Ophth. *58*:694 (Sept.-Oct.) 1954.
3. Kunkle, E. C.: Central Causes of Vertigo, J. South Carolina M. A. *50*:161 (June) 1954.

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. . . . THE PRESIDENT'S PAGE . . . .

THE State Medical Society of Wisconsin now has over 3,300 members. It is my hope that as the president of the Society I can serve the interests of each and every member. My ability to do this will depend upon knowledge of your wishes. Too frequently, I believe, we think in terms of the organization and less in terms of the individual. With your help I would like to reverse that tendency because in so doing—that is, in placing more emphasis on the individual opinion—more can be accomplished for the organization.

I am as interested in the problems of the practitioner in Vilas, St. Croix, Walworth or any other county as I am in the problems to be encountered in Madison or Milwaukee. I want to take this opportunity to invite your suggestions and to ask that you send me your problems. Not that I can solve them personally—but you can be assured that at least all of the enthusiasm and interest that I can muster will be directed toward helping you through our organization, through the various committees, and through the executive staff.

Criticism is easy to come by. Constructive suggestions, productive thought, and a willingness to help solve problems are not as plentiful. I want to encourage your interest. I want you to make your voice heard where it will do the most good.

Make it a point to know the committee structure of our Society. Familiarize yourself with the chairmen and membership of those committees. The job they are doing is often a thankless one, and your interest and expressions of your ideas will be welcome to them. The committees and the Council are also worthy of this interest and attention.

Do you feel that the Editorial Board is doing a good job with the Journal? Are you active and interested in civil defense planning for your community? The Committee on Civil Defense would like to know plans which have been made in your community. What you are doing may be the solution to what should be done elsewhere. Are the prepaid plans of the State Medical Society well supported by the community and by the doctors in your area? Are they well received by the industrialists?

If you are interested in knowing more about the operation of your Society, reliable, authentic information is available.

Irvin L. Bernhart M. D.

Society Proceedings

Eau Claire–Dunn–Pepin

Members of the Eau Claire–Dunn–Pepin County Medical Society met on May 23 for dinner at the Durand Rod and Gun Club, Durand. Dr. S. B. Mills of the pediatrics department of the Mayo Clinic, Rochester, Minnesota, was the guest speaker. He discussed purpura in children.

Drs. R. J. Bryant and *I. L. Blose*, Durand, were hosts for the meeting. During the scientific portion of the program, the wives of members were entertained at the Bryant home.

Manitowoc

Dr. R. C. Randolph, Manitowoc, was elected president of the Manitowoc County Medical Society at the May meeting of the society held at the Hotel Manitowoc. *Dr. D. A. Kuljis*, Two Rivers, was named vice-president, and *Dr. R. J. Banker* of Manitowoc was chosen secretary-treasurer. Following the business meeting, there was an informal discussion on the Salk vaccine inoculation program.

Milwaukee

The May 26 meeting of the Medical Society of Milwaukee County was held at the Brooks Memorial Union of Marquette University. The scientific program consisted of a panel discussion on "Recent Advances in Treatment of Tuberculosis." Panel members were Drs. H. T. Barkley, Houston, Texas; T. L. Badger, Boston; Mario Fischer, Duluth; and J. L. Wilson, Philadelphia. Dr. W. B. Tucker of Durham, North Carolina, served as moderator. Among the subjects covered in the discussion were the best drug treatment for TB, surgery's place in the treatment of TB, and advantages and disadvantages of home care for TB patients. This program was presented in cooperation with the National Tuberculosis Association.

Pierce–St. Croix

Dr. F. A. Springer, Elmwood, was the host at the May 17 meeting of the Pierce–St. Croix County Medical Society held at the Dibbo Hotel in Hudson. The guest speaker for the evening, Dr. G. F. Hartnagel of the Interstate Clinic at Red Wing, Minnesota, gave a talk on the progress and results of the Minnesota Maternal Mortality Study. The doctor stated that the figures on maternal deaths were about equal for Wisconsin and Minnesota. The two states are among the lowest in the nation in this respect.

During the business meeting, a letter of commendation to the society from *Dr. E. H. Pawsat* of Fond du Lac, chairman of the School Health Division of the State Society, was read. He complimented the county society for the excellent School Health Conference they sponsored at the Wisconsin State College in River Falls on April 5. This was the first such program conducted by a county medical society.

Price–Taylor

Meeting at the Skyline Club, Phillips, on May 21, members of the Price–Taylor County Medical Society heard talks by three Marshfield physicians. *Dr. J. R. Heersma* discussed "The Rational Use of Antibiotics in Pediatrics"; *Dr. B. R. Lawton* spoke on "The Diagnosis of Cancer of the Lung"; and *Dr. T. H. McDonell* chose "Repair of the Surgically Injured Ureter" as his topic.

Racine

Members of the Racine County Medical Society heard an address by Dr. Morris N. Gelfman of Milwaukee at their May 19 meeting at the Meadowbrook Country Club, Racine. Doctor Gelfman discussed "The Neuroses."

Rock

On May 24 the Rock County Medical Society met at the Monterey Hotel in Janesville to hear a program on health insurance problems. The speakers were Mr. Paul Doege, sales coordinator of Wisconsin Physicians Service, and Mr. Robert Froehlke, assistant secretary of the Hardware Mutuals Insurance Company, Stevens Point.

Winnebago

The regular monthly meeting of the Winnebago County Medical Society was held at the Elks Club, Neenah, on June 2. Featured on the program was a movie from the Wyeth Laboratories describing treatment of streptococcal infections.

Milwaukee Neuro-Psychiatric Society

The Milwaukee Neuro-Psychiatric Society held its annual dinner meeting at the University Club, Milwaukee, on May 18. Dr. Henry A. Davidson, assistant superintendent, Overbrook Hospital, Cedar Grove, New Jersey, read a paper on "The Psychiatrist as an Expert Witness."

The Society elected the following officers for the year 1955–1956:

President—*John Petersik*, Winnebago

Vice-president—*David Cleveland*, Milwaukee

Secretary-treasurer—*Isaac J. Sarfatty*, Milwaukee

Councilors—*Francis J. Millen*, Milwaukee; *Benjamin A. Ruskin*, Wauwatosa

Wisconsin Academy of General Practice

Over 200 general practitioners attended a symposium on office procedures and clinical medicine sponsored by the Wisconsin Academy of General Practice and Lederle Laboratories Division, American Cyanamid Company, on June 24 in Madison. *Drs. C. F. McDonald*, Milwaukee, president of WAGP; *Raymond Richards*, Eau Claire, president-elect; and *Samuel Sorkin*, Evansville, president of the Madison area chapter, were hosts at the meeting.

Among the speakers was Dr. A. J. Steigman, professor of child health, University of Louisville, Louisville, Kentucky, who discussed polio diagnosis. He stated that many minor illnesses which mimic polio are causing parents undue fear.

Dr. Christopher Duncan, clinical associate in gynecology, Harvard University, Boston, discussed infertility, stating that the incidence of success in the infertile couple has doubled in the last 20 years, and outlining a program for examination and therapy of infertile couples.

In discussing management of the oliguric patient, Dr. L. W. Bluemle, associate in medicine, University of Pennsylvania, Philadelphia, divided this management into three stages: first, when the objective is to prevent maximal tubular damage; second, when the objective is to maintain optimal internal environment in the absence of renal function; and third, when there are complex problems of fluid and electrolyte replacement at a time when tubular reabsorption of these substances is impaired.

Three responsibilities of the physician in office management of allergy, according to Dr. G. I. Blumstein, assistant professor of medicine, Temple University, Philadelphia, are: relief of presenting symptoms; identification of offenders; and prophylactic or curative treatment.

"Management of Fractures of the Extremities about the Joints," was the title of a talk given by Dr. Paul A. Pemberton, associate professor of surgery, University of Utah, Salt Lake City. He said that two principles which should be taken into consideration to a greater degree here than in the usual fractures occurring in other parts of the limbs are: it is more important to preserve function in the involved joint than it is to restore exact apposition of the fracture fragments, and in such fractures there will probably be some permanent disability.

Dr. J. P. Nesselrod, associate in surgery, Northwestern University, Evanston, discussed "Common Anorectal Disorders, Their Pathogenesis, Diagnosis, and Treatment."

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News Items and Personals

Doctor Larson Moves to Ashland

Dr. Harry H. Larson became associated with *Drs. J. M. Jauquet* and *W. J. Tucker* in Ashland on June 15. He had been practicing at Grantsburg for the past two years and also has practiced in Rice Lake. He was graduated from the University of Wisconsin Medical School in 1952 and interned at St. Luke's Hospital, Duluth.

Doctor Taylor Attends Meetings

Dr. Robert Taylor, Marshfield, recently attended a meeting of the directors of the American Heart Association in Cleveland. Then going to Atlantic City, New Jersey, he attended the American Medical Association meeting. He is a member of the House of Delegates of the A.M.A., representing the section on experimental medicine. In addition, he was a participant in the inauguration of a new section of the meeting patterned after the section, "Queries and Minor Notes," of *The Journal of the American Medical Association;* his contribution was in the field of cardiovascular diseases.

Before returning to Marshfield, Doctor Taylor stopped in Milwaukee, where he is supervising a research group and carrying on a teaching program at Marquette University.

New Physician at Whitehall Clinic

Dr. Joseph Tschetter, an eye, ear, nose, and throat specialist, recently became associated with the MacCornack Clinic at Whitehall.

He is a graduate of the University of Illinois Medical School and interned at Grant Hospital, Chicago. After eight years of practice at Woonsocket, South Dakota, he took postgraduate work in eye, ear, nose, and throat at the University of Illinois and the Cleveland Clinic. He completed a two-year residency at the University of Colorado Medical Center and hospitals, Denver. Since 1943, he has been practicing at Huron, South Dakota. He is a past president of the section on ophthalmology and otolaryngology of the South Dakota Medical Society.

Doctor Goetsch Receives "Heart Oscar"

Dr. F. H. Goetsch, Spooner, recently received a "heart oscar," presented by the Wisconsin Heart

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Association. These statuette awards were given chairmen conducting successful campaigns during the February Heart Fund Drive.

Wausau Physician Named President-Elect of Blood Bank Group

Dr. O. R. Kelley, Wausau, was named president-elect of the Wisconsin Association of Blood Banks during the annual meeting of the group held in Madison on June 4. He will take office a year from now, succeeding R. F. Ambelang, Milwaukee.

Doctor Kelley is also the Wisconsin representative to the American Association of Blood Banks. He has served as director of his local blood bank since its organization, April 1, 1952. During the Madison meeting he presented a paper on "Donor Procedures."

Paul F. Doege Medical Center, Marshfield, Operating Since December

The Paul F. Doege Medical Center has been operating in Marshfield since the last part of December. Associated in the center are *Dr. Paul F. Doege* and *Dr. Robert Taylor*, who came to Marshfield on January 1.

Doctor Doege is a graduate of the Harvard Medical School, where he served as instructor of pathology during the two years following his graduation. He was house surgeon at Boston City Hospital before returning to Marshfield in 1930, when he joined the Marshfield Clinic, an institution of which his father, the late Karl W. Doege, was a founder. A founder member of the Wisconsin Surgical Society, Doctor Doege is also a fellow in the American College of Surgeons and is a fellow of the International College of Surgeons.

Doctor Taylor, who received his medical degree from Northwestern University, was associated with the Cleveland Clinic for the last 10 years, practicing in the field of internal medicine, and also served as associate professor of medicine at Bunts Educational Institute in Cleveland. He interned at the Passavant Memorial Hospital in Chicago, and he was a resident at the Indianapolis City Hospital and the Lilly Laboratories from 1940 to 1943. He served in the Army Medical Corps in 1943–1944. From 1944 to 1945, he was on the attending staff at Indianapolis City Hospital and was instructor in medicine at the Indiana Medical School. Doctor Taylor is a fellow and life member of the American College of Physicians. He has held the position of director in the American Heart Association and has been president of the American Federation for Clinical Research.

The new Paul F. Doege Medical Center has three doctors' suites, a lounge, business office, laboratory, examining rooms, and surgical dressing room.

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THIRD AND TWELFTH DISTRICTS NEWS

Dr. C. O. Miller Moves to Monroe

On July 1, *Dr. C. O. Miller*, who has been in practice in Monticello since 1953, became associated with *Drs. D. D. Ruehlman, C. E. Baumle, John Irvin,* and *D. W. Springer* of Monroe. This group is now building a new medical center in Monroe.

Doctor Tenney Speaks to Community Welfare Council

Dr. H. Kent Tenney, Madison, was one of three members of a panel which discussed "Madison Looks Ahead 10 Years in Welfare, Recreation and Health" at the annual dinner meeting of the Community Welfare Council Meeting of Madison, held at the East Side Business Men's Association Clubhouse on May 25. Other speakers on the panel included Helen I. Clarke, professor of social work at the University of Wisconsin, and Glenn Holmes, director of health, physical education, recreation and safety in Madison public schools.

Doctor Parkin Named President of States Medical Postgraduate Association

Dr. Robert C. Parkin, Madison, was elected president of the States Medical Postgraduate Association at the A.M.A. convention in Atlantic City, New Jersey. The postgraduate association coordinates subject matter and dates of postgraduate programs and encourages physician participation in them. Doctor Parkin is director of postgraduate education at the University of Wisconsin Medical School.

Milwaukee Physicians Speak, Present Exhibit, on Epilepsy

Dr. E. D. Schwade, Milwaukee, spoke at the Nation's First Conference on Neurological Disorders in Industry held in Chicago recently. He discussed "Historical, Medical, and Legal Aspects of Epilepsy."

He and *Dr. Sarah Geiger*, also of Milwaukee, presented an exhibit entitled "Behavior Disorders of the Impulsive-Compulsive Type with Consistent Abnormal EEG Findings," at the annual meeting of the American EEG Society.

Physicians Speak at Forum on Arthritis

A public forum on arthritis was held on June 7 at the Vocational School auditorium in Madison. *Dr. Edwin Welsh*, head of physical medicine at Columbia and St. Luke's hospitals in Milwaukee, was the main speaker. Serving with Doctor Welsh on a panel for the question-and-answer period were *Drs. D. Murray Angevine* and *A. W. Bryan* of Madison.

Physicians Visit Eli Lilly and Company

Among physicians from southern Wisconsin visiting the Eli Lilly Company in Indianapolis recently

were *Drs. George Parke*, Richland Center; *Leo W. Peterson* and *J. F. Behrend*, Sun Prairie; *B. H. Brunkow*, Monroe; *A. C. Edwards*, Baraboo; and *E. H. Grumke* and *Carl Fosmark*, Madison. Several pharmacists also went on the tour.

Doctor Larkin to Take Residency Training

Dr. C. B. Larkin, Madison, began a residency in internal medicine at St. Mary's Hospital there on July 1. He has been in Madison since his graduation from the University of Wisconsin Medical School in 1949, except for a period in military service. He interned at Madison General Hospital.

SOCIETY RECORDS

New Members

G. J. Kirn, 1836 South Avenue, La Crosse.

W. S. Donnell, 1101 Kingston Avenue, Racine.

C. S. Youngstrom, 15711 Birwood, Detroit, Michigan.

J. F. Riordan, 102 East Second Street, Kaukauna.

E. N. Wright, 46 Washington Boulevard, Oshkosh.

G. D. J. Griffin, 110 East Main Street, Madison.

W. C. Mussey, 113 North Carroll Street, Madison.

Margaret C. Winston, 1300 University Avenue, Madison.

T. J. DeKornfeld, 2549 Van Hise Avenue, Madison.

J. H. Juhl, 1300 University Avenue, Madison.

E. F. Purcell, 110 East Main Street, Madison.

G. G. Kring, 2 West Gorham Street, Madison.

Changes of Address

D. W. Pranke, Beloit, to 4705 Montrose Boulevard, Houston, Texas.

O. S. Blum, Monroe, to 6034 Indian Creek Drive, Miami Beach, Florida.

Thomas Rutter,** La Crosse, to Surgical Service, U. S. Army Hospital, Fort Leonard Wood, Missouri.

L. B. McCabe,** Fond du Lac, to 154 Birkhead Road, Village 2, Fort Sam Houston, Texas.

R. F. Lamb, Fort Sam Houston, Texas, to 1000 East 10th Street, Casa Grande, Arizona.

E. L. Tharinger, Milwaukee, to P. O. Box 991, Naples, Florida.

G. A. Dall, Fort Sam Houston, Texas, to 2802 North 74th Street, Milwaukee.

T. S. O'Malley, Milwaukee, to Route 1, Box 50, Thiensville.

J. A. Schelble, % Postmaster, New York, to 2320 North Lake Drive, Milwaukee.

J. W. Terry, Fort Campbell, Kentucky, to 2634 North Third Street, Milwaukee.

W. K. Hoffman, Philadelphia, Pennsylvania, to 5522 West Washington Boulevard, Milwaukee.

Stephen Cahana, Los Angeles, California, to 8108 North Santa Monica Boulevard, Milwaukee.

W. D. Shapiro, St. Paul, Minnesota, to 161 West Wisconsin Avenue, Milwaukee.

** Military Service.

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

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Brown, H. W.: J. Pediat. 45:419, 1954.

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R. S. Pelton, Markesan, to 416 Watson Street, Ripon.

J. D. Spankus,** Milwaukee, to 746th Trp. Carr. Sq. (M), Charleston Air Force Base, South Carolina.

J. C. Kyllo, Superior, to 8333 North 29th Avenue, Phoenix, Arizona.

P. M. Lucas, Monticello, to Veterans Administration Hospital, Wood.

F. W. Van Kirk, Beverly Hills, California, to 2060 Pacific Avenue, San Francisco, California.

H. H. Larson, Grantsburg, to Ashland.

** Military Service.

DEATHS

Dr. David H. Lando, Sr., 75-year-old Milwaukee physician, died on April 27, 1955.

He was born on October 10, 1879, in Milwaukee. He graduated from Milwaukee Medical College in 1901 and served his internship at Milwaukee County Hospital. A general practitioner, Doctor Lando had also practiced in Merrill; Camp Pomona, Illinois; Waukesha; and Davenport, Iowa.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Doctor Lando's widow, Rae L.; daughter, Rose; and son, David, Jr., M. D., survive him.

Dr. Adellon Andrus, Ashland, died on May 22 at an Ashland hospital. Born April 15, 1883, at Fairchild, Wisconsin, he was 72 years of age at the time of his death.

Doctor Andrus received his medical degree from the University of Colorado, Boulder, Colorado, in 1912; interned at St. Joseph's Hospital, Ashland; and served his residency at the Wisconsin State Tuberculosis Sanatorium at Wales, Wisconsin.

During World War I, he served in the medical corps of the U. S. Army. Receiving his discharge in 1919, he returned to Ashland, where he practiced continuously until his retirement in the fall of 1954. He served as Ashland County physician for many years, and was also medical officer for the U. S. Indian Service for eight years.

Doctor Andrus was a member of the Ashland County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his wife, Blanche; a sister, Mrs. Harding R. Hogan, La Grange, Illinois; and several nieces and nephews.

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It has been said that disease is not a static condition but evolves over a period of time and from a set of multiple causes. If this is true, then it is of great benefit to the person getting sick to see his doctor as early in the course of a disease as is possible since by this that person considerably aids himself in his return to good health. He is in effect helping himself to live a better life. This advantage plus the security of sickness without severe, sudden financial loss are both possible outcomes of a health insurance such as Blue Shield. The advantages to the physician are of a more subtle nature and revolve about his ability to maintain better health in the community.

In general, it would seem that the long-term effects (of Blue Shield) lie most entirely in the development of a widespread change of attitude of the usually healthy person toward health and disease and the doctor . . . Too often the patient is seen—for the first time—long after much can be done to help him, or only after the stage of a disease has been reached where it has become unnecessarily disfiguring or debilitating. Now then, if you couple a persistent awareness by a person of the possibility of disease along with the financial security that Blue Shield offers and the opportunity to use medical services, quite logically the result is the sick person will attend to these services at an earlier date. In doing so, health insurance has then indirectly played a good role in the earlier diagnosis and treatment of disease, and who can deny this to be anything but advantageous? . . .

. . . The "quack" doctor stands a lesser chance of promoting his nostrums if a person realizes he can use the best in medical technique through the use of his Blue Shield . . . The child learns of Blue Shield from his parents and so the more the parents are aware of the physician, the more the discussion of medicine is promoted in the the family circle . . . Starting thus, the child will come to take medicine as an accepted part of his environment rather than just some agent to encounter when getting sick . . .

If we can believe all the above benefits to be possible, there is only one further question to be asked and that is: "Will people use Blue Shield enough to definitely aid the promotion of these results?" The answer to this question is very likely "yes," for this reason. Blue Shield policies are an investment—just like bonds or cars or houses. It is human nature for people making an investment to want to get just returns; that is, to really get their money's worth. People won't hesitate about using Blue Shield plans as often as they possibly can! With this in mind, everybody is sure to benefit from these policies: first, the patient; second, the community; and third, the doctor.

* By Sheldon L. Wagner, Madison, student at the University of Wisconsin Medical School. This was the only Wisconsin entry in the recent Student A.M.A.–Blue Shield Essay Contest.

For Information or Advice

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RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by examination by the State Board of Medical Examiners at a meeting in Madison, January 11 to 13, 1955.

Name	*School of Graduation*	*Year*	*Address*
Affeldt, Thomas O'Donnell	Marquette University	1953	5760 Kensington Rd., Detroit, Mich.
Alt, William Jacob	University of Michigan	1953	University Hospitals, Madison
Dalton, Ruth Margaret	University of Illinois	1953	925 Mound St., Madison
DeKornfeld, Thomas John	Harvard Medical School	1953	2549 Van Hise, Madison
Duncan, Wallace Wayne	Johns Hopkins University	1953	University Hospitals, Madison
Ewer, Robert Wayne	Northwestern University	1953	3021 N. 76th St., Milwaukee
Finegan, Robert Franklin	Northwestern University	1952	University Hospitals, Madison
Griem, Melvin Luther	University of Wisconsin	1953	7120 N. Beach Dr., Milwaukee
Howland, Donald Everett	University of Wisconsin	1953	Mendota State Hospital, Madison
Jacobson, Lewis Leo	Chicago Medical School	1954	Eagle River
Lloyd, Baldwin Evan	University of Wisconsin	1952	602 Third, S. E., Mason City, Ia.
Misch, Allen	University of Wisconsin	1952	U. S. Air Force Hospital, Enid, Okla.
Neal, Marcus Pinson, Jr.	University of Tennessee	1953	University Hospitals, Madison
Smith, Dean Barton	Northwestern University	1952	4345 Britta Place, Madison
Thompson, Margaret Alice	University of Wisconsin	1953	Mendota State Hospital, Madison
Voet, Raymond Kenneth	Marquette University	1951	2320 N. Lake Dr., Milwaukee
Volini, Gloria Marie	Loyola University	1952	7220 W. Center St., Milwaukee
Watson, David Spore	Northwestern University	1953	University Hospitals, Madison
Werner, David Anthony	University of Wisconsin	1953	1424 Union Ave., Sheboygan

The following physicians were granted licenses by examination by the State Board of Medical Examiners at a meeting in Madison, April 14 and 15, 1955.

Name	*School of Graduation*	*Year*	*Address*
Bobo, Edward Charles	Howard University	1953	2442A 17th St., Milwaukee
Conners, Dean Matthew	University of Wisconsin	1952	University Hospitals, Madison

(Continued on page 36)

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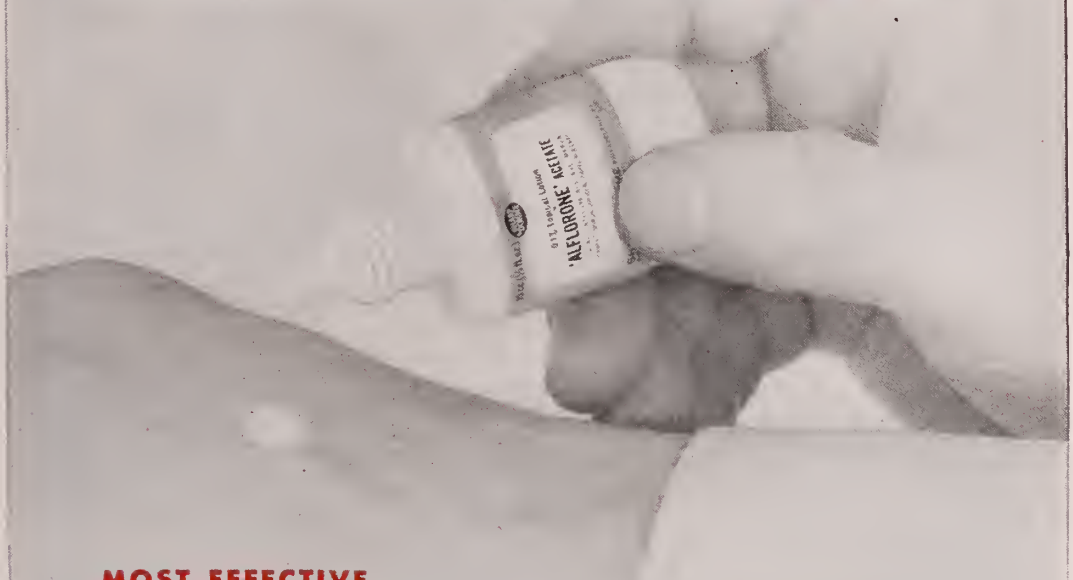

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(Continued from page 34)

Name	School of Graduation	Year	Address
Cooper, Hugh Edwin, Jr.	University of Illinois	1953	2524 W. Glendale, Milwaukee
Eichman, Peter Liebert	Jefferson Medical College	1949	1300 University Ave., Madison
Griem, Sylvia Marie Fudjinski	University of Wisconsin	1953	7120 N. Beach Dr., Milwaukee
Honeycutt, John Holcombe	University of Washington	1953	University Hospitals, Madison
Spengler, John Robert	St. Louis University	1953	3105 Kenwood Blvd., Toledo, Ohio

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Madison, January 11 to 13, 1955.

Name	School of Graduation	Year	Address
Adams, Lyle Eugene	University of Illinois	1951	St. Mary's Hospital, Wausau
Ainslie, Robert Brown	University of Rochester	1937	16 S. Henry St., Madison
Andrews, William Jay	University of Illinois	1947	1215 Forest Ave., Oak Park, Ill.
Baird, William Wendell	University of Cincinnati	1947	6210 W. Greenfield, West Allis
Boston, Thomas Edward	University of Tennessee	1949	554 S. High St., Hillsboro
Boutwell, William Staples	Northwestern University	1950	26151 Huron River Dr., Flat Rock, Mich.
Brokken, Jack Ridley	University of Minnesota	1952	10437 Watertown Plank Rd., Milwaukee
Bryant, John Edmond	Howard University	1937	Bayfield Sanitorium, Bayfield
Costello, Addis Clement	Marquette University	1951	324 E. Wisconsin Ave., Milwaukee
Currie, Robert English	University of Colorado	1952	2953 N. 50th St., Milwaukee
Feuling, John Charles	University of Minnesota	1931	402 Medical Arts Bldg., Duluth, Minn.
Kennedy, Ralph Oliver	University of Wisconsin	1950	3416 Oakwood, Ann Arbor, Mich.
Kuzera, John Anthony	Loyola University	1952	15309 Center, Harvey, Ill.
Lauerman, Edward Phillip	University of Chicago	1948	312 Seventh St., Racine
Morrissey, John Fielding	Harvard Medical School	1949	2419 Norwood Place, Madison
Philpot, Van Buren, Jr.	Tulane University	1950	University Hospitals, Madison
Schmidhofer, Ernst	Illinois University	1937	Milwaukee County Asylum, Milwaukee
Simpson, Eber Edward	Washington University	1921	Route 4, Box 742, Oshkosh
Wickliffe, Robert Caldwell McChord	University of Louisville	1951	456 Deming St., Chicago, Ill.

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The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Madison, April 14 and 15, 1955.

Name	*School of Graduation*	*Year*	*Address*
Barrow, David Woolfolk	Harvard Medical School	1935	8700 W. Wisconsin Ave., Milwaukee
Bickford, Robert Harold	State University of Iowa	1947	1505 Main St., Stevens Point
Blunck, Conrad Frederick	University of Illinois	1947	University Hospitals, Madison
Cales, John Othal	University of Oklahoma	1942	Monroe Clinic, Monroe
Docksey, John Warren	Marquette University	1950	1851 N. Oakland Ave., Milwaukee
Doehlert, Charles Alfred	University of Pennsylvania	1949	1227 Third Ave., S. W., Rochester, Minn.
Fortier, Edward Gerald	Northwestern University	1948	3533 W. 116th St., Chicago, Ill.
Gelfman, Morris	University of Colorado	1947	9035 Watertown Plank Rd., Milwaukee
Griffin, George Daniel	Loyola University	1947	110 E. Main St., Madison
Hill, Wallace Clark	McGill University, Montreal, Quebec	1943	308½ S. Superior, Albion, Mich.
Hillenbrand, Henry Melvin	St. Louis University	1947	Mercy Hospital, Oshkosh
Hughes, John	University of Cambridge	1953	Beaver Dam
Janicek, Donald Roy	University of Wisconsin	1951	110 E. Main St., Madison
Kearney, Walter Reuben	Loyola University	1945	1146 Washington, Fayetteville, Ark.
Kearns, John Westhofen	Johns Hopkins University	1947	238 W. Wisconsin Ave., Milwaukee
Krause, Richard Michael	Western Reserve University	1952	Camp Manito-wish, Boulder Junction
Kring, Gerald Grant	Northwestern University	1948	2 W. Gorham St., Madison
Logue, John Terrell	Duke University	1948	16 Markwood Dr., Columbia, Md.
Miller, Milton Howard	Indiana University	1950	University Hospitals, Madison
Mintz, Alfred Martin	Jefferson Medical College	1947	208 E. Wisconsin Ave., Milwaukee
Mussey, William Clive	University of Minnesota	1946	113 N. Carroll, Madison
Nash, Charles Bernard	Loyola University	1937	508 Milwaukee St., Janesville
Peterman, Albert Frederick	Washington University	1952	Mayo Clinic, Rochester, Minn.
Purcell, Edward Francis	Jefferson Medical College	1949	110 E. Main St., Madison
Rennebohm, John Alwin	University of Wisconsin	1952	Carnavillo, Ia.
Wachtel, Philip Leon	Washington University	1951	Milwaukee Children's Hospital, Milwaukee
Ylitalo, Willliam Henry	University of Minnesota	1946	2 W. Gorham St., Madison

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CORRESPONDENCE

The President
The White House
Washington 25, D. C.

My dear Mr. President:

Thursday evening Mrs. Tenney and I had the privilege of hearing a rebroadcast of part of your press conference as given on Edward R. Murrow's program. As you finished speaking we spontaneously turned to each other and said, "There is a truly great man." And, as we discussed your obviously reverent compassion for the bereaved individual, and your resolute determination to be resolute, but patient, on the international scene, we agreed that the world is indeed fortunate in having in the White House a man who shows so many of the characteristics of Abraham Lincoln. And that, Sir, is about the highest praise we can give to anyone in public life.

But then, Mr. President, with a great feeling of sadness, I was forced to say, "Goodness, how I wish he was not so dedicated to that blasted reinsurance program." For I must admit that during my recent term of office as president of the State Medical Society of Wisconsin I frequently expressed my opposition to the plan, and, if the occasion should arise again, I shall be forced to repeat my opposition. And this truly saddens me because I am so sure that your objectives and the objectives of the medical profession are absolutely identical. Those of us who oppose your plan honestly believe that it will not only fail to achieve those objectives, but will in all probability weaken the presently successful and expanding prepayment insurance movement. But what saddens me even more, Mr. President, is that I have not yet heard the voice of medicine say to you, in effect, "Mr. President, your goal for the health of the American people and our goal for the health of the American people are absolutely identical. We believe, however, that your plan will not work. But, Mr. President, here is a plan which calls for a pooling of the intellectual, the spiritual, and the financial resources of both government and medicine; and when those resources are pooled, the plan will work." This, Sir, is what must some day be said and I am sure some day will be said. So my plea to you, Mr. President, is this: please try to show the same patience and forbearance toward organized medicine that you are showing toward far more serious international irritations. The vast majority of physicians throughout the world agree wholeheartedly with all your objectives, and those of us in organized medicine who oppose your reinsurance plan do so because we honestly believe that it won't work. Some day some smart physician will come up with a cooperative plan of action, and then we will all be happy.

I do not expect that this letter will ever reach your desk so I need not apologize for wasting your time. But, if statistics are kept in regard to the content of letters, let this one be listed as a family voting increasingly enthusiastically for you as President, and one sad but determined physician's vote against your reinsurance plan.

Very respectfully yours,
/s/ H. KENT TENNEY, M. D.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON

Doctor H. Kent Tenney
1 South Pinckney Street
Madison 3, Wisconsin

Dear Doctor Tenney:

Your letter of December 7 was sent to me from the White House for reply.

I appreciate your sincere interest in seeing the President's objectives in the health field met successfully; but, as a physician, I myself have great difficulty in understanding why organized medicine has expressed such opposition to the reinsurance proposal. It is my considered opinion that this proposal is not only a desirable one that will encourage insurance organizations to move faster in providing better benefits for more people; it also provides a sound safeguard against a more far-reaching governmental operation. I am sure that the President and Secretary Hobby share your wish to do the most effective possible job in improving the health of the American people. By the same token I believe that they both consider the health reinsurance plan to be an important step in the right direction.

Thank you very much for your thought-provoking letter. It is through expressions of opinion such as yours that better understanding resolves.

Sincerely yours,
/s/ CHESTER S. KEEFER, M. D.
Special Assistant to the Secretary for Health and Medical Affairs

Chester S. Keefer, M. D.
Special Assistant to the Secretary
for Health and Medical Affairs
Department of Health, Education and Welfare
Washington, D. C.

Dear Dr. Keefer:

Many thanks for your reply to my letter to the President. I had really not expected a reply and am consequently much pleased to get it.

If you have not already done so I am sure you will be interested in reading the enclosed speech by Edwin J. Faulkner, President, Woodman Accident,

and Life Company, which was presented at the recent meeting of the AMA in Miami. To my mind Mr. Faulkner gives a perfectly adequate explanation of why reinsurance is not the answer we are all seeking. But it is not enough to say that Government does not belong in the field of insurance unless we follow up with a statement as to where Government does belong. Because anyone who denies, or fails to recognize, that the participation of Government in the health of the nation is inevitable and, within certain bounds, a desirable sociologic and political trend is simply denying or failing to recognize a fact of life. So, if I am to be consistent, I feel that I must very briefly outline my ideas.

Government can, has, and should make its most significant contribution in the ever-expanding field of preventive medicine. For example: Here in Wisconsin it was about seventeen years ago that the Bureau of Maternal and Child Health, using considable Federal funds, initiated, and has continually pushed, an educational program in the fields of obstetrics and pediatrics. This required, and received, the cooperation of the State Board of Health, the State Medical Society, county medical societies, and individual physicians as well as the people who had and were having babies. Now, to say that the downward trend in maternal and infant mortality in these seventeen years has been due to this campaign is perhaps not entirely justified. But to say that this campaign played a major role in bringing about this trend is entirely justified and (at least to an old pediatrician like me) is little short of thrilling. But, unfortunately, the State Board of Health is finding it necessary to curtail some of its preventive programs because of the curtailment of Federal funds. And when I learn that the Board feels that because of this curtailment it can do no more than "scratch the surface" in mental health activities I am really disturbed. Because, to my mind, mental health is the number one medical problem facing the world today. We are saving more infants and we are making old folks become even older; but what is the use of all that if we do not at the same time make more sure than we do now that all these people have a better chance at achieving that serenity of spirit which is man's true heritage and which is the true objective of all mental health activities.

So my suggestion is this: Take that $25 million away from the reinsurance scheme, where it does not belong and where it has little chance of doing any good, toss it into the hopper marked "mental health," where it does belong and where it can do a lot of good, and then watch a lot of physicians rally around you and wish you well.

I suppose I should apologize for adding to your already heavy mail but actually I am glad to have met you, even at such long range, because to anyone who remembers the early antibiotic days the name of Chester Keefer rings an unforgettable bell.

Sincerely yours,

/s/ H. Kent Tenney, M. D.

Department of Health, Education, and Welfare
Washington

Dr. H. Kent Tenney
1 South Pinckney Street
Madison 3, Wisconsin

Dear Dr. Tenney:

Thank you very much for your thoughtful letter of December 28th enclosing Mr. Faulkner's speech in Miami. It was kind of you to send it to me, and I have read it again after having been present at the meeting of the House of Delegates in Miami when he presented it.

I have known of Mr. Faulkner's position on the reinsurance bill since last year, and I have read everything that he has written about it. He presents his case well, but he is in disagreement with many other equally competent insurance executives on many major points. The original bill was drafted after consultation with highly qualified experts in the insurance field, including Blue Cross, Blue Shield and private insurance carriers, including men from insurance companies that do a tremendous business in reinsurance in the life and other insurance fields. There was no misunderstanding of the function of reinsurance by the Administration or by the expert consultants in the insurance field who helped with the drafting of the bill.

Mr. Faulkner makes the point that "in life insurance, for example, reinsurance makes it possible for an insurer to assume larger risks than it could without reinsurance. But in health insurance the situation is different. Here there is almost never a concentration of risk large enough to require spreading a potential loss. Even with catastrophic or major medical expense insurance, which presents the maximum amount of risk usually found on one life, the insurer's potential loss is seldom as much as $10,000, a sum well within the capacity of all but the smallest insurers to carry alone."

The reinsurance bill was not designed to cover the reinsurance of a *single* risk, but it was designed to reinsure *plans* and *plans* in the aggregate. That is to say, if company "X" issued a catastrophic or major medical expense policy to a large group (10,000 people) and each policy carried a potential loss of $10,000, then there would be a concentration of risk large enough to require a spreading of potential loss. In fact, this is precisely what some of the large group insurance companies do when they sell a major medical contract to an industry and the potential loss in the aggregate is greater than they want to assume alone.

Insurance companies of considerable size tell us that it is virtually impossible for them to experiment with health insurance plans involving an untried risk because of the lack of experience and the difficulty of spreading the risk.

Mr. Faulkner also states that "The trifling volume of health reinsurance business now being done reflects not inadequate reinsurance facilities in the private market but an absence of need for reinsurance." There are other reasons for the lack of reinsurance at present in the health field: (1) In the case of Blue Cross with service benefits, the hospitals are the reinsuring agencies; (2) In the case of Blue Shield with service benefits, the doctors are the reinsurers; and (3) The cash indemnity insurance companies have not used reinsurance widely because of the limited and comparatively low and uniform benefits they provide and the volume of business that they spread on their books. In the language of the insurance companies, when there is uniformity of the limits written, and when the benefits on individual contracts are low and the total number of contracts large, the exposure or potential loss is small and the need to share the risk is unnecessary.

The reinsurance fund would give the medium-sized companies (those with assets between 75 and 100 million dollars) a better chance to serve the insurance buying public on a broader and sounder basis. It is their belief that with the larger number of companies who would be able to offer broader coverage—many of them located in less populated areas of the country—a substantial number of presently uninsured citizens could acquire health insurance protection and service. They express the opinion that the plan would encourage them to experiment in areas that they cannot enter at present.

The 25 million dollars that you mention was a capital fund, and any use of capital funds would be repaid from reinsurance premiums.

In brief, the reinsurance proposal would be:

(1) Voluntary for each carrier.

(2) Regulation of carriers would remain with the *States*.

(3) Operate only where comparable reinsurance is not available.

(4) Reinsure abnormal losses only.

(5) The carrier shares in losses (coinsurance).

(6) Federal liability limited to the fund (25 million dollar authorization, plus reinsurance premiums).

(7) Non-subsidy basis (self-supporting).

Your comments about extending preventive medical services and mental health activities are extremely sound, and I am certain that when you read the President's Health Message you will be pleased.

I assure you that sound opinions and judgments such as yours are most helpful because we are all interested in improving the health of our people and encouraging individual responsibility for health. We must educate the people to protect themselves against the unpredictable costs of illness through individual planning and prepayment voluntary health insurance plans.

There is general agreement on the point that the value of any health protection policy must ultimately be measured in terms of its benefit payments. At present there is need for improvement in the health insurance plans that are offered by more than 900 companies in the United States. Anything that the medical profession can do to improve the benefits to the insured will improve the position of the medical profession.

Sincerely yours,
/s/ CHESTER S. KEEFER, M. D.
Special Assistant to the Secretary for Health and Medical Affairs

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R. W. SCHMITT, M. D.
Northwoods Hospital
Phelps–Vilas County, Wisconsin

Dr. J. M. Sullivan
Editorial Director
Wisconsin Medical Journal
Box 1109, Madison 1, Wisconsin

Dear Doctor Sullivan:

I want to warmly compliment you on the editorial, "Temple of the Soul," on page 319 of the June issue. Such thoughts will carry us towards the solution of our problems—problems of the individual and problems of the organization.

Sincerely yours,
/s/ R. W. SCHMITT, M. D.

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PHYSICIANS' EXCHANGE

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PRACTICE AVAILABLE in town of 6,500 for purchase of all or part of office equipment. Address replies to Box 611 in care of the Journal.

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WANTED: Certified public health nurse. Address replies to Mr. Walter Frederick, 621 E. Quincy St., New London, Wis.

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THE WISCONSIN MEDICAL JOURNAL

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Volume 54 AUGUST 1955 Number 8

Regional Enteritis: Problems in Its Management*

By J. ARNOLD BARGEN, M. D.**
Rochester, Minn.

Definition

REGIONAL enteritis is a disease that is seen mainly in young adults and is typified clinically by abdominal cramps, diarrhea, fever, loss of weight, anemia, and perianal abscesses and fistulas.

The lesions of regional enteritis usually are limited, both in the initial and recurrent stages of the disease, to the terminal portion of the small intestine. However, regional enteritis may occur anywhere in the small intestine, either in localized or diffuse form. The lesions also may involve the colon for variable distances, usually as a process continuous with that in the small intestine. Characteristically, the lesions are granulomatous, necrotizing, ulcerating, and cicatrizing processes, frequently accompanied by fistulas arising from the small intestine and extending to either neighboring viscera or the abdominal wall. Histologic findings can be divided into primary and secondary processes. The primary process, consisting mainly of lymphatic obstruction and edema, permits the claim that the disease has a definite pathologic picture, whereas the secondary process supplies the nonspecific inflammatory component.

Incidence

Between 1912 and 1949, inclusive, 600 patients received a diagnosis of regional enteritis at the Mayo Clinic.[1] From 1912 to 1921, there was about one patient each year. The number began to increase from then on, and the diagnosis was made nine times in 1931. In the years 1941 to 1949, the diagnosis occurred about 40 times each year, with a maximum of 55 in a single year. This refers to new patients only. The disease began at the age of 4 years in 2 of this group of patients; in 336 of the 600 patients, it occurred between the ages of 16 and 30, and it began between the ages of 70 and 74 in 3 patients. Those of northern European extraction numbered 428, whereas 153 were Hebrews and 11 were Italians; there was only 1 Negro in this group. The length of time that the patients had had symptoms of the disease varied from six months to 37 years; 342 of them had had symptoms between 1 and 8 years.

Pathology

No lesion remotely simulating regional enteritis was encountered above the pylorus in this series of cases. Abrupt termination of the disease process was found distally (1) at the ileocecal valve in 53 per cent of the cases in which the lesions were in the initial stage and (2) at the enterocolonic stoma in 78 per cent of the cases in which the process was recurrent.

The custom of classifying the lesions of regional enteritis as acute, subacute, or chronic is helpful. Interpretation of the acuteness of the process depends on the degree of serosal vascular engorgement, both venous and capillary, present in the lesion and associated mesentery, coupled with the appearance of the fibrinous exudate often found over the lesion and neighboring peritoneum. The acute lesions vary from bright red to dusky blue according to the degree of venous obstruction and relative amount of reduced hemoglobin contained within the vascular channels. In contrast, the chronic lesions assume a normal hue and lack the vascular engorgement and fibrinous exudate. Many adhesions resulting from organization

* Presented at the meeting of the Milwaukee Surgical Society and the One Hundred and Fourteenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, May, 1955.

** Section of Medicine, Mayo Clinic and Foundation. The Mayo Foundation is a part of the Graduate School of the University of Minnesota.

of previous fibrinous exudate are present. Structures simulating the tubercles of tuberculosis occasionally appear in the serosa. The intestine exhibits an inordinate thickening and stiffening in both acute and chronic phases; in the former phase, these changes result from inflammatory edema, whereas they are caused in the latter phase by proliferation of fibrous tissue.

Mesenteric alterations pursue a similar pattern, with vascular engorgement and edema in the acute phase and proliferation of fibrous tissue in the chronic stage. The mesentery in the acute stage is often 1 cm. or more in thickness, tending to encompass the intestinal lesion and contributing generously to the abdominal mass. Thickening in the chronic phase is not often pronounced.

The lymph nodes are invariably enlarged, both in the acute and chronic stages. They attain large dimensions in the acute process, often measuring up to 4 cm. in diameter. In the chronic phase they are somewhat smaller and are firm, but still are much larger than those encountered in normal mesentery.

Abscesses and fistulas are frequent complications of the intestinal lesions. The abscesses are encountered adjacent to the involved intestine, their walls being formed by omentum, mesentery, normal intestine, bladder, and parietal peritoneum. Abscesses occasionally are encountered within the mesentery. Fistulas often connect the diseased intestine with the external surface of the abdomen or with adjacent loops of small intestine, the neighboring cecum, the sigmoid, or the urinary bladder, or with the pelvic viscera in women.

The proximal portion of the intestine frequently is dilated because of obstruction. This feature, accompanied by adhesions and abscesses, often renders it difficult for the surgeon to determine the exact extent of the disease process. The presence of free peritoneal fluid appears to depend on intestinal obstruction and must be considered apart from the fibrinous exudate previously mentioned.

When the intestinal lumen is opened, certain characteristic ulcers are encountered. These ulcers are prone to occur along the mesenteric border, from which they generally extend in an irregular fashion, dividing the entire mucosa into isolated islands of intact epithelium. The prominence of these islands varies with both the depth of the ulceration and the amount of mucosal and submucosal inflammation. These ulcers usually are covered with a shaggy, grayish-white exudate. The ulcers in the proximal portion of the lesion lose their irregular nature, become more discrete, and often occur in mucosa that otherwise appears normal grossly. If they again coalesce and assume their irregular nature, the process is described as a "skip lesion." These skip lesions occasionally are separated from the main lesion by portions of normal mucosa of variable size, the so-called skip areas; usually, however, localized ulcerations, retaining their tendency to maintain a location on the mesenteric border, occur between them. In otherwise normal intestine, ulcerations are found adjacent to the distal ends of enterocolonic fistulas.

Another type of ulceration occurs in the obstructed intestine with pronounced distention. This is the stercoraceous ulceration, which has no etiologic relationship to the ulceration of regional enteritis. It occurs in any obstructed dilated intestine. In contrast to the ulceration of regional enteritis, it tends to be shallow and to involve the mucosa opposite the mesentery.

The most prominent gross feature in regional enteritis is the pronounced thickening of the intestinal wall. The submucosa contributes a considerable portion of this thickness and, on closer examination, frequently reveals numerous hyperplastic lymphoid follicles. This thickening of the intestinal wall occasionally is masked by distention, which results from obstruction at a region corresponding to the distal portion of the lesion.

Pathogenesis

Some evidence exists to suggest that the causative agent may be found in the fecal stream and that it appears initially in the proximal part of the small intestine. It may be carried by the fecal stream, from which it is absorbed by the small intestine. Its production and absorption probably are related in some way to the physiologic activity of the small intestine. If this agent resides in the fecal stream, it may exert its influence on the normal epithelial cells in the region of the future lesion, causing them to be replaced by goblet cells. The possibility of whether or not such an epithelial change occurs elsewhere in the intestinal tract has not been studied.

Tubercles and lymphoid hyperplasia develop when the etiologic agent gains entrance into the interstitial spaces of the intestinal wall. The further course of the agent appears to be by way of the lymphatic vessels, where it causes focal intralymphatic endothelial hyperplasia. Lymphatic obstruction and dilatation occur as a result of this lymphoid hyperplasia and lymphatic endothelial proliferation. This obstruction promotes further intraluminal lymphatic cellular accumulations and interstitial edema. Partial intestinal obstruction from the primary pathologic process causes a numerical increase in intestinal bacteria. The interstitial edema and lymphatic obstruction, in turn, decrease the resistance of the mucosa to bacteria, with the result that ulceration develops. Fistulas and abscesses appear later owing to extension of the ulcerative process through the wall of the intestine. Reichert and Mathes[2] demonstrated experimentally that lesions simulating regional enteritis can be produced by lymphatic blockage; this process was accentuated by intravenous injection of bacteria.

Assuming that the causative factor is in the fecal stream, it may increase in either quantity or toxicity or both during its progress down the intestine. If this hypothesis is correct, that portion of the small intestine exposed to the greatest concentration or activity of the substance is the lowermost portion, just above the ileocecal valve, or just above the site of enterocolostomy in cases in which resection has been performed. That the disease process stops so frequently at the point of junction with the colon, both initially and when it is recurrent, may indicate that the colon possesses certain inherent differences from the small intestine. One main difference is the ability of the latter to absorb nutrients. This suggests that the specific agent is related to one of the nutrients and, as already mentioned, requires the operation of a physiologic process to gain entrance into the intestinal wall. When regional enteritis spreads so as to involve the colon adjacent to the ileocecal valve, near the site of an enterocolostomy or next to a fistula, the process loses certain gross characteristics, particularly the tendency of the ulcers to occur in linear fashion along the mesenteric border. The large intestine generally is not involved so extensively as is the small intestine. The histopathologic findings, however, differ little from those encountered in the small intestine.

The points of exit of the intestinal lymphatic vessels are at the mesenteric border; moreover, interstitial fluid tends to diffuse in this direction. Therefore, the mesenteric border is the region exposed to the greatest concentration of the etiologic agent. Hence, the ulcerations tend to occur here first and show their most extensive development in this location.

Pathologic changes in the terminal portion of the ileum subsequent to the feeding of sand and talc were reported in 1946 by Lichtman and associates.[3] More extensive but similar studies have been described since. Any similarity between lesions produced by sand or talc and those of regional enteritis lies in the possibility that, in regional enteritis, an agent exists in the fecal stream which is able to produce and sustain a chronic infection. Lichtman's group made no claim that, because granulomas are encountered in both classes of lesions, an etiologic relationship exists between them.

Bacterial, protozoal, and viral agents all have been advocated as causes of regional enteritis, as have sarcoid, allergy, and trauma. For none of these has any conclusive evidence been provided, and current opinion is that none has etiologic relationship to regional enteritis. However, intestinal allergy cannot be excluded as a possible cause.

In reviewing the records and follow-up letters of 600 patients with this disease, I was impressed by the number who claimed that certain foods caused exacerbation of the disease. There was a wide variety of such foods, among which milk was prominent. The fact that some of the most desperately ill patients can be restored to normal health and can remain healthy if a certain food is omitted from the diet is strong evidence of a cause-and-effect relationship. Some of the vascular changes noted are those associated with allergic reactions. Moreover, the entire primary pathologic process, including the formation of tubercles, is such that to entertain the idea of an allergic cause of a type related to an Arthus or Shwartzman phenomenon does not appear unreasonable.

The virus of lymphopathia venereum has been suggested as the cause. Curtiss,[4] in a recent review of the literature, was unable to find mention of a single case in which le-

sions of lymphopathia venereum extended proximal to the midportion of the transverse colon. However, this observation does not exclude the possibility of the existence of a related virus with a specific predilection for the terminal portion of the small intestine.

Emsbo[5] recently has recognized a similarity between regional enteritis and a disease affecting swine. The two diseases are identical in that both produce an edematous, granulomatous, necrotizing, and ulcerating process in the terminal part of the small intestine. The tendency for the ulcerations to occur along the mesenteric border is found in both, and is accompanied by lymphatic dilatation and accumulation of epithelioid cells, with and without giant cells. Pathogenic bacteria have not been found in the lesions of swine, nor has the disease been produced experimentally in swine by feeding ground-up portions of intestinal lesions, by induction of avitaminosis, or by trauma.

Symptoms

The symptoms include colicky or continuous pain, diarrhea alternating with constipation, fever, bleeding, abdominal mass, abscesses and fistulas about the anus, and loss of weight. The pain is either colicky or continuous, depending on whether actual or physiologic obstruction is present. Continuous pain and tenderness usually are located in the right lower quadrant of the abdomen. The diarrhea in these patients at times is severe but is more likely to be intermittent, alternating with constipation. Indications of rapid transit of intestinal content, resulting in frequent loose stools, are extremely common. Fever is a frequent accompaniment of this disease. Pronounced increase of temperature sometimes occurs and may be the only or most predominant symptom of enteritis; thus, these patients may come to the physician with what appears to be fever of undetermined origin, and innumerable tests may be done in an attempt to find its cause. Unless the physician is wary, he may forget that intestinal disease is a fairly common cause of obscure fever.

Although not uncommon, bleeding is not so frequent a symptom as are the others mentioned. At times, however, massive hemorrhage may be the most prominent of all the symptoms; and these patients may have exsanguinating hemorrhage. The passage of black blood is unusual. The findings of an abdominal mass in the right lower quadrant of the abdomen occur rather frequently.

Complications

The complications of regional enteritis include fistulas and abscesses in the abdomen, obstruction, massive hemorrhage, anemia, deficiency states, disturbances of growth and development, ischiorectal abscesses and rectovaginal fistulas, and arthritis. Their frequency of occurrence is about in the order listed. By and large, the first three are commonly surgical problems.

Treatment

Instead of considering this disease as one in which the primary treatment is surgical, as was thought two decades ago, my colleagues and I have become very conservative in the surgical treatment of regional enteritis. The average patient is now treated nonsurgically. The treatment at best is not too satisfactory. However, a number of measures have been helpful.

The use of sulfonamides such as phthalylsulfathiazole (Sulfathalidine) and salicylazosulfapyridine (Azulfidine), a high-protein diet, administration of extra vitamins, and attention to the fluid balance and satisfactory nourishment are of the greatest importance. One helpful therapeutic measure has been roentgen therapy. My associates and I ordinarily use 130 kv. to 200 kv. in treatment. The anterior abdominal wall is blocked off into four fields, two on each side of the midline extending from the xiphoid to the pubis. One field is irradiated on one day with a dose of about 133 r. If the patient is in comparatively good condition, the four fields are irradiated in four days. Otherwise, the treatment is divided into half sessions. Most people do not get sick enough as the result of this treatment to require administration of pyridoxine, but it is usually given as a precaution. If the patient is stout, an electromotive force of 200 kv. is used, with a dose of 125 to 150 r. These patients ordinarily receive three courses of roentgen therapy a month apart; after that, treatment is repeated on the basis of the clinical findings.

At the present time, surgical treatment is largely limited to the complications of the disease and, as already indicated, not all complications become surgical problems. The following cases illustrate some of the complexities of regional enteritis.

Report of Cases

Case 1.—A 49-year-old man came to the clinic in December, 1953, with a history of loose stools and abdominal cramping since 1945. The trouble was mild at first and did not interfere with his ordinary activities.

The condition became worse from 1951 to 1953, during which time his weight decreased from 170 to 125 pounds.

Examination revealed a value for hemoglobin of 8.9 Gm. per 100 ml. of blood; leukocytes numbered 10,600 per cubic millimeter. The erythrocytic sedimentation rate was 62 mm. during the first hour (Westergren method). Roentgenograms of the colon revealed what appeared to be diverticulitis of the sigmoid; those of the small intestine showed evidence of regional ileitis of the distal foot of the ileum. A 24-hour specimen of stool contained 32 per cent fat, dry weight.

Surgical exploration confirmed the findings, and resection of the distal portion of the ileum and resection of the sigmoid, with proximal colostomy, were done. The main reason for exploration was the obstructive feature of diverticulitis. The symptoms in this case undoubtedly were due to both conditions.

The colonic stoma was closed a month later. The patient returned for a checkup in March, 1955, at which time he was in good condition.

* * *

Case 2.—A 49-year-old man came to the clinic in June, 1954, because of diarrhea and abdominal cramping since December, 1951. The hemoglobin measured 11.8 Gm. The erythrocytic sedimentation rate was 44 mm. Serum proteins measured 6.66 Gm. per 100 ml.

Roentgenograms of the colon showed constriction of the sigmoid with perforation and an ileosigmoidal fistula. Roentgenograms of the small intestine showed regional enteritis; numerous entero-enteric fistulas between loops of small intestine were present in the right lower quadrant of the abdomen. It was obvious that surgical treatment would require extensive resection. The patient's general condition was good, and roentgen therapy was prescribed.

When he returned in September, 1954, he looked well and had gained 5 pounds. The number of stools was reduced, and he said he felt well. Roentgenologic study still showed ileosigmoidal fistulas.

His last examination was in March, 1955, at which time he was 10 pounds heavier than he had been when first examined. He was having two or three stools daily and generally felt extremely well. The hemoglobin measured 12.4 Gm. Roentgenograms still showed the ileosigmoidal fistula, but there was less retrograde flow of barium through it. He felt so well that surgical intervention was again postponed.

* * *

Case 3.—A 41-year-old man first came to the clinic in January, 1955. He had been discharged from the army in December, 1945, having served in Europe; at that time he was apparently well. In June, 1946, he had noted onset of distress in the right lower quadrant of the abdomen and periodic vomiting; during 1947, he was inclined to vomit his lunch and supper. Exploratory laparotomy had been done in December, 1949, and a "growth" of the terminal part of the ileum was resected. The patient was told that this might have been caused by a hard crust of bread embedding itself in the intestinal wall. A pathologic diagnosis of regional ileitis was made. He had been well, then, until December, 1950, when he had had enough trouble to warrant hemorrhoidectomy.

He then had remained well for almost a year, when diarrhea and pain in the right lower quadrant developed. These symptoms had continued intermittently but had become worse in September, 1954, when they were so severe that he had to quit work. In October, 1954, he had undergone ileocolostomy. In November, 1954, he had experienced what was called a perforation of the cecum ("the cecum burst into something"). The pain in the right lower quadrant had continued after the operation, and he had had periodic distention of loops of intestine.

When he was first seen at the clinic in January, 1955, his hemoglobin measured 12.4 Gm. The sedimentation rate was 19 mm. Serum proteins measured 5.5 Gm. with 2.9 Gm. of albumin and 2.6 Gm. of globulin. Roentgenologic examination revealed evidence of regional ileitis at the ileocolonic stoma. Symptomatic treatment resulted in improvement.

He returned in February, 1955, stating that he had been well until two weeks previously, when he noted severe pain in the right lower quadrant with severe diarrhea; later, symptoms of periodic obstruction al-

ternated with diarrhea. Examination at this time revealed a huge fluctuant mass in the right lower part of the abdomen that bulged into the rectum anteriorly. His temperature was 103 to 105 F. daily, and the abdomen was distended. A double-lumen tube was passed. Antibiotics, including chlortetracycline (Aureomycin) and penicillin, were given. Fluid balance was established. One week after admission, following severe pain, the patient had more diarrhea. The mass in the right lower quadrant receded after this. His rectal discharges from this time on were liquid, resembling the contents of the small intestine. A tentative diagnosis of ileosigmoidal fistula was made. The mass receded to about a quarter of its original size.

Exploration was undertaken for an ileosigmoidal fistula and recurrent regional enteritis; a total of 40 cm. of the terminal part of the ileum and 30 cm. of the right side of the colon was removed. Regional enteritis was present above the ileocecal junction, with pronounced thickening of the intestinal wall. Ulcers up to 6 cm. in length were present. The intestine above the narrowed region of greatest involvement was dilated due to obstruction. The diseased intestine measured 30 cm. in length. The colon was not involved. Postoperative convalescence was uneventful.

* * *

Case 4.—A 35-year-old man first came to the clinic in November, 1953. He had begun to have loose stools, two to five or more daily, at the age of 14 years. An anal fistula had appeared at that time. After that he had experienced one new anal fistula almost every year, and there followed numerous fistulectomies and seven plastic repairs to the rectum between 1947 and 1953. He had undergone resection of the right side of the colon and the terminal portion of the ileum for regional ileitis in 1939; this was followed by a second resection in 1942 and a third in 1945.

Examination at the clinic in November, 1953, gave evidence of a jejunocolic anastomosis with obstruction at that site. An end-to-side anastomosis had been done, leaving a blind loop of jejunum that apparently had filled up and became greatly dilated. Surgical revision of the jejunocolonic stoma and removal of the obstructive loop were done in December, 1953. The patient's postoperative convalescence was satisfactory until the summer of 1954.

Profound anemia had developed through the years from 1939 on, becoming more severe after removal of the ileum prior to the patient's coming to the clinic. Between 1939 and February, 1955, he had received more than 500 pints of blood. In 1954, he had three transfusions before going on a vacation in July. In September and December, 1954, he required four transfusions; but in the two months before a return visit to the clinic in February, 1955, he had 14 transfusions, which increased his hemoglobin from 5 to 10.8 Gm. the week before he came. The hemoglobin promptly decreased, and in a week it was 7.9 Gm. This last visit was made primarily because of total incontinence.

Examination at this time revealed a large patulous opening at the site of the patient's former anus that would admit three fingers. He was hospitalized, and attempts were made to determine the nature of his anemia. Extensive studies, including observations by means of radioactive chromium, led to the conclusion that the anemia was due to loss of blood.

In spite of a reluctance to recommend further surgical intervention, it was thought that something had to be done to stop the leakage of blood. Exploration was done and extensive ulceration at the entero-enteric stoma was found, for which further resection of the jejunum and jejunocolostomy were done. Studies utilizing radioactive chromium were repeated after the operation, and no loss of blood was detected. The patient's hemoglobin two months after operation was still 11.8 Gm., the best value he had had in many years. No one knows how long this will continue, of course.

* * *

Case 5.—A 24-year-old man was first seen at the clinic in March, 1955. Since July, 1952, he had complained of nausea, vomiting, abdominal cramps and pain, and abdominal distention; these symptoms were intermittent at first but later became almost constant, with much borborygmus over the entire abdomen. He had been in the army during most of this time and was hospitalized during the last four months of his army stay (from October, 1953, through January, 1954). He had been discharged from the army in February, 1954. His weight had decreased from 170 to 113 pounds. In August, 1954, he had been examined at the Veterans Administration, and no intestinal trouble was found.

Six weeks prior to his admission to the clinic, the pain had begun to localize as a soreness in the right lower quadrant of the abdomen. The pain had been much worse since then. He had induced vomiting to relieve the pain. The passage of gas or a large bowel movement would relieve the cramping pain. He had experienced periodic chills and fever, with as many as 8 to 10 stools a day.

Examination at the clinic in March, 1955, revealed a large suprapubic mass that was particularly hard and tense. The hemoglobin measured 10 Gm.; the leukocytes numbered 18,900. The value for serum protein was 5.1 Gm., of which 2.98 Gm. was albumin and 2.12 Gm. was globulin. Roentgenologic examination revealed evidence of regional ileitis with a huge distended loop of intestine proximal to the involved segment. A week was spent in cleaning out the intestine; during this time the mass became much smaller and the periodic cramps decreased.

Surgical exploration revealed what had been anticipated; namely, regional enteritis with pronounced obstruction, dilatation of the ileum above, and entero-enteric fistulas. Resection of the involved segment and ileo-ileostomy were done. Examination of the surgical specimen showed regional ileitis with greatly dilated intestine and mucosal gangrene for a distance of 14 cm. The remainder of the removed intestine showed multiple linear regions of ulceration and edema. An entero-enteric fistula was present at the site of the stricture. Convalescence was uneventful.

* * *

Case 6.—A 44-year-old man came to the clinic in December, 1953. He had had periodic abdominal cramps, fever, and diarrhea since 1947. In February, 1951, he had undergone ileocolostomy and intestinal resection. In May, 1952, he was having more trouble than he had had before. When seen at the clinic in December, 1953, he had been experiencing rather severe colicky pains and diarrhea with blood.

The value for hemoglobin was 13 Gm.; the sedimentation rate was 81 mm. Roentgenograms showed involvement of the ileum both proximal and distal to the site of anastomosis. Roentgen therapy was given in three courses, a month apart. The patient had abdominal distress and a low-grade fever for one week after completing the treatments. Since then he improved and has felt entirely well for the last year.

Follow-up examination in April, 1955, disclosed a value for hemoglobin of 12.8 Gm., with an erythrocyte count of 4,830,000. The sedimentation rate was 61 mm. Roentgenologic studies still showed involvement of the ileum proximal and distal to the anastomosis. The patient was asymptomatic, however.

* * *

Case 7.—A 38-year-old man came to the clinic in January, 1947, after having had a previous resection for ileitis, which had been present for 14 years. He was found to have extensive recurrence of the disease, and roentgen therapy was prescribed. He did very well for several years, but in the last year he again experienced more trouble.

A follow-up examination in April, 1955, showed roentgenologic evidence of recurrent regional enteritis, although the general picture had not changed since his examination two years before. The value for hemoglobin was 10.5 Gm.; serum proteins measured only 5.52 Gm., so the patient was given two blood transfusions of 500 cc. each. This made him feel very much better generally. It was suggested that he resume treatment with azopyrin, a combination of cobalt chloride and ferrous sulfate (Roncovite), and a high-protein diet, with a return for recheck in four to six months.

Prognosis

Of the aforementioned 600 patients, 402 had definitive surgical treatment and 400 survived operation. It would be wonderful if that told the whole story. Of these 400 patients, 135 did not have recurrence of the disease during the period of observation. Another group of 135 patients had recurrence of regional enteritis; in 49 patients, it appeared within six months after the definitive operation, whereas it appeared within the next six months in 32. From then on, increasingly fewer patients had recurrence, so that only one recurrence was noted in the fifteenth year.

Surgical treatment included partial exclusion, complete exclusion, resection, and ileostomy. During the entire study, primary resection was done 265 times. Recurrence was noted in 125 of one group of 203 patients, a rate of 62 per cent. A subsequent recurrence rate of 81 per cent was noted among 61 patients who had recurrent regional enteritis and underwent a second surgical procedure. A slightly greater recurrence rate

was present among Hebrews than among other races of patients. The recurrence rate among the former was 77 per cent, whereas it was 59 per cent among the latter.

These figures point to the extremely difficult and serious problem encountered in the management of regional ileitis.

Comments

It is apparent that the thinking of physicians about regional enteritis has changed considerably in the last 30 years. Whereas at one time it was thought to be primarily a surgical disease, surgical intervention now is limited largely to complications. Regional enteritis tends to be a relentlessly progressive intestinal inflammatory process; thus, removal of the diseased segment frequently does not accomplish the desired end. It is a condition associated with most unpleasant complications that are frequently difficult to manage. The management of this disease frequently taxes the physician's ingenuity; while some of these patients do extremely well, the disease in many others appears to march on inexorably.

It is obvious that roentgen therapy is not the last word in the treatment of regional enteritis; but it is a good second best, if not a best, from the standpoint of present-day treatment. It is to be hoped that better measures of therapy will be available in the not-too-distant future.

Mayo Clinic.

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1955 FALL PROGRAM—WISCONSIN SOCIETY OF ANESTHESIOLOGISTS

University Hospitals, Madison

Saturday, September 17, Room 300, University Hospitals

Cardiovascular Research Laboratory Activities, C. W. Crumpton, M. D., Director

2:00– 2:20 Cardiac Output, Left Ventricular Work and Coronary Blood Flow in Mitral Stenosis—John Huston, M. D.
Discussion*

2:30– 2:50 Physiologic Changes Produced by Angiocardiography—George G. Rowe, M. D.

3:00– 3:15 Coffee Break

3:15– 3:35 Determination of Residual Volume and Total Lung Capacity by a Single Breath Technique—John Rankin, M. D.

3:45– 4:45 Panel Discussion—Anesthesia for Cardiac Catheterization and Angiocardiography—Jeanne Anderson, M. D., John Juhl, M. D., David Noll, M. D., George G. Rowe, M. D.

5:00– 5:30 Board of Directors' Meeting

6:30 Dinner—**Reservations *must* be received at the Anesthesia Department, Room 420D, University Hospitals, Madison, by September 12.** Wives are invited.

Sunday, September 18, Room 300, University Hospitals

9:30–10:00 Coffee Wake Up—For the "Early Birds"
Chairman—Paul E. Campbell, M. D., Waukesha, President

10:00–10:20 Lidocaine in the Treatment of Ventricular Fibrillation—Norman Carden and John E. Steinhaus, M. D.

10:30–10:50 Cardiac Irregularities as Related to Endotracheal Intubations—Robert T. Capps, M. D.

11:00–11:20 Death Due to the Anesthetist—Milton Davis, Jr., M. D.

11:30–12:15 Nitrous Oxide-Thorazine Anesthesia—Jack Moyers, M. D., Division of Anesthesiology, University of Iowa Hospitals

12:30– 1:00 Business Meeting

1:00 Dinner—Cafeteria, University Hospitals

2:00– 2:30 Anesthetic Problems in Patients with Thoracic Disease—Karl Siebecker, M. D.

2:30– 3:30 Symposium—Anesthesia for Intestinal Obstruction—O. Sidney Orth, M. D., Chairman
Betty J. Bamforth, M. D., Dale Hoff, M. D., William Kreul, M. D., Jack Moyers, M. D.

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* Ten minutes for each paper.

Diphyllobothriasis (Fish Tapeworm Infestation)

A Case Report and Review of Current Concepts*

By ROBERT F. MADDEN, M. D., and MARK W. GARRY, M. D., F. A. C. P.
Wood

HUMAN infestation with fish tapeworm, Diphyllobothrium latum, is reportedly a medical rarity in Wisconsin. The record of a patient diagnosed and treated for diphyllobothriasis at the Veterans Administration Hospital, Wood, Wisconsin, is presented; and current concepts relating to the disorder are discussed.

History and Laboratory Findings

The patient, a 29-year-old railroad section worker, entered the hospital on September 8, 1954, complaining that he had been passing "worms" in his stools for the past one and one-half months. He had had several episodes of moderate diarrhea for the same length of time but denied tarry or grossly bloody stools. Additional symptoms were frequent gagging, occasional emesis, ease of fatigue, and a 10-pound weight loss. These had been present since the onset of the present illness. The patient's diet in the preceding three months had included fresh bullheads and perch taken from Lakes Michigan, Army, and Mukwonago, and Northern and walleyed pike caught by a relative in southern Manitoba. The patient recalled that some of the fish may have been inadequately cooked. He also stated that his young six-year-old son had been passing worms in his stools for approximately the same length of time.

Past medical history and systemic inventory were otherwise noncontributory.

Physically, the patient's appearance was one of good general health. Despite the weight loss, he did not appear malnourished. No significant abnormalities were found on complete physical examination.

Laboratory investigation disclosed 14 Gm. of hemoglobin and 4,300,000 red blood cells. The total white blood cell count was 7,800 with a 7 per cent eosinophilia. The urinalysis results were normal, and the Westergren sedimentation rate measured 23 mm. per hour. With a view toward substantiating the impression of intestinal helminthiasis, stool specimens were obtained on the ward and at the time of proctoscopy. These were examined immediately after collection, and the ova of D. latum were identified in each specimen.

Fig. 1—The tapeworm. The head is invisible above. The large gravid segments below break off and are noted by patients in the stool.

Course in the Hospital

After several stool specimens had been examined and the causative organism positively identified, treatment was begun. This consisted of a clear liquid diet for a 48-hour period, followed on the evening of the second day by one ounce of 50 per cent magnesium sulfate. The next morning, 1 Gm. of Atabrine was given orally, followed within two hours by 1 ounce of Glauber salts solution (50 per cent sodium sulfate). Within the hour after the second purgative, the entire tapeworm was passed per rectum. The scolex (head) was visible at one end of the worm, which measured 17 feet in length and contained 525 segments. Other than mild nausea, satisfactorily controlled by 25 mg. of chlorpromazine (Thorazine), the patient's subsequent course was uneventful. He left the hos-

* From Veterans Administration Hospital, Wood, Wisconsin, and Marquette University School of Medicine, Milwaukee.

pital feeling well on September 17 after nine days of hospitalization.

Discussion

D. latum was first recognized as a species of tapeworm in 1602 by Plater in Basel, Switzerland.[1] However, it was not until 1777 that it was clearly differentiated from the beef and pork tapeworms. In 1858, Weinland noted the disease in American immigrants from the Scandinavian countries.[1] The first authentic cases of American origin were reported by Ward and by Nickerson in 1906 in separate papers concerning patients in northern Michigan and Minnesota.[1]

The parasite inhabits many fresh water lakes and rivers in the north temperate zone. In Europe it is found chiefly in the lake regions of Switzerland and Rumania and in the Danube basin and the Scandinavian countries. In North America there are three principal endemic areas: the northern peninsula of Michigan; northern Minnesota, and the vicinity of Winnipeg, Manitoba.[2] The epidemiological studies of Essex,[3] Magath,[3] and Vergeer[4] have shown that these North American areas are becoming increasingly infected. In their studies, about 20 per cent of the Northern and walleyed pike examined in 1931 were found to harbor the parasite. In the United States the greatest concentration has been at Shagwa Lake (formerly Long Lake) in northern Minnesota. Weinstein and Appelget,[5] in an examination of fish from Shagwa Lake in 1950, found the following incidence of parasites: Of 11 Northern pike, 100 per cent were found to be infected; of 65 walleyed pike, 81.1 per cent were found to be infected; and of 10 yellow perch, 10 per cent were found to be infected. Subsequent work shows the entire northern Minnesota watershed to be infected. Similar recent studies are not available from northern Michigan and Manitoba, but the frequency of human infections in these areas indicates a high concentration. D. latum is only occasionally found in Great Lakes fish because the cold water universally present tends to inhibit the hatching of the coracidia (larvae), thus breaking the life cycle. Other recognized endemic areas in the United States are in the Lake Tahoe and Mount Lassen, California, watershed.[3]

In the state of Wisconsin there is no information available on the incidence of infestation as the disease is not reportable except in the event of an outbreak.[6] A survey of the major Milwaukee hospitals reveals a total of 7 proved cases since 1945.[7]

In the life cycle of D. latum there are two intermediate hosts, the copepods of the crustacean genera Cyclops and the aforementioned fresh water fish. The definitive host is usually man. Dogs, cats, foxes, and many other mammals may also be reservoir hosts; but it is believed by most investigators that these are relatively unimportant in the incidence of the parasites. The life cycle begins when the ova, which are found in large numbers in feces, are excreted into or near a stream or lake. If the water is warm enough (50 F.), the ova hatch 9 to 12 days later into a hexacanth larva which is known as a ciliated coracidium. The larva swims about for several days until it is ingested by a cyclops. In the intestinae of the cyclops the larva loses its cilia and invades the intestinal wall, gaining access to the body cavity. Here it enlarges and is now known as a procercoid. The next step is the ingestion of the infected cyclops by a fresh water fish, most likely a pike or perch. Soon the procercoid penetrates the intestinal wall of the fish and enters the muscle, connective tissue, and viscera. The consumption of improperly cooked infected pike or perch then establishes the parasite in the gastrointestinal tract of man or other mammals. Fecal contamination (containing the ova) of fresh water streams and lakes perpetuates the cycle.

Clinical Features

Most patients with diphyllobothriasis are relatively asymptomatic. A history of eating raw or poorly cooked fish can usually be elicited. Some patients may experience mild abdominal cramps or diarrhea but do not usually seek medical aid for this. There may also be a report of unusual weight loss in spite of an excessive appetite. Definitive diagnosis rests upon identification of proglottides (segments) or ova in the stool by trained laboratory personnel.

An interesting facet of tapeworm infestation as reported in various European medical journals is the presence of an associated macrocytic anemia indistinguishable from pernicious anemia. According to Wintrobe,[8] several explanations are advanced for this complication. One view leans toward defective absorption of the extrinsic factor; another is that impaired gastric secretion

produces an actual deficiency of the intrinsic factor; still other theories include liberation of a hemolysin (Tallqvist) and an allergic reaction by the bone marrow. The most generally accepted theory holds that tapeworm infestation precipitates the disease in an individual constitutionally predisposed to pernicious anemia. In any event, the overall occurrence of the anemia is decidedly rare, attaining an incidence of 0.1 per cent to 0.2 per cent in 550 cases in Finland. To date there has been no reported American case of pernicious anemia in infested persons. As a rule the anemia responds to parenteral vitamin B_{12} or simply expulsion of the parasite.[9–10]

Treatment of the infestation is essentially the same as outlined in the case report and is directed toward the expulsion of the entire worm. It consists of a clear liquid diet on the day preceding treatment, then purgation with 1 ounce of Glauber salts (50 per cent sodium sulfate) or 1 ounce of 50 per cent magnesium sulfate solution. Early the next morning either 20 minims of fresh oleoresin of aspidium or 1 Gm. of Atabrine is administered orally. (We used Atabrine because it stains the worm a bright yellow, making it easier to identify the head.) Following this specific medication, the purge is repeated in two hours; and soon thereafter the worm is usually passed. If there is no immediate expulsion, stools should be examined for 24 hours or until the head is passed, at which time the treatment is completed. If the head is not identified, there is no proof that the entire worm has been eradicated; and it will probably redevelop in three to five months, with a recurrence of symptoms. Treatment should not be repeated until after a three-month period.[11]

The prevention of fish tapeworm infestation depends upon establishing a break in the life cycle of the parasite. This can be accomplished in any one of several ways available to public health authorities: by keeping sewage out of fresh water lakes and streams; by chlorination of known infested water; and by restricting the sale of fish from heavily infested waters.[1] The surest preventive measure which may be employed by the individual is the destruction of the larvae by thoroughly cooking the fish for 15 minutes at temperatures over 50 C. or by freezing at –10 degrees C. for 24 hours.[12]

Summary

1. A case of Diphyllobothrium latum infestation is presented because of its unusual occurrence in this area, and a report of successful treatment is given.

2. Pertinent epidemiologic, clinical, and prophylactic features of the disease are discussed.

(R.F.M.) Veterans Administration Center.

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WISCONSIN SOCIETY OF INTERNAL MEDICINE

On September 17 the newly formed Wisconsin Society of Internal Medicine will have its first meeting in Monroe, Wisconsin. Internists interested in becoming members may contact the secretary, Dr. William Coffey, Jr., 536 West Wisconsin Avenue, Milwaukee.

Dr. Maurice Hardgrove, Milwaukee, is chairman of the organization committee forming this new society, and its executive secretary is Mr. James E. Eiss.

The First Medical Faculty of the University of Wisconsin*

Part I

By WILLIAM S. MIDDLETON, M. D.**
Washington, D. C.

CASUAL observation would accord the University of Wisconsin Medical School relative youthfulness among the institutions of learning in the United States. In its present form as an integral element of the University, its birth date may be given as 1907, when the first organized preclinical course was offered in the catalog, under the deanship of the late Charles Russell Bardeen. Even this essential stage was under the direct and dominant control of the College of Letters and Science. Chapter 99 of the Laws of Wisconsin Territory, approved January 19, 1838, provided "That there shall be established at or near Madison, the seat of government, a university for the purpose of educating youth, the name whereof shall be 'the University of Wisconsin.'" On March 2, 1848, Governor Dodge approved a bill, incorporating "The Wisconsin Medical College" in or near Milwaukee, that had been passed by the last session of the Legislative Assembly of the Territory of Wisconsin. The project died aborning without historical evidence of any effort in its consummation.

On May 29, 1848, Congress approved admittance of Wisconsin to the Union. In this removed period when integration and coordination are shibboleths of some cogency, Section 6, Article X of the Constitution of the State may be read with particular interest: "Provision shall be made by law for the establishment of a state university, at or near the seat of state government, and for connecting with the same, from time to time, such colleges in different parts of the state as the interests of education may require." In the act incorporating the University of Wisconsin, signed by Governor Nelson Dewey on July 26, 1848, Section 8 reads: "The University shall consist of four departments: First, the department of science, literature and the arts; second, the department of law; third, the department of medicine; fourth, the department of the theory and practice of elementary instruction." The Second Report of the Regents indicates compliance with the expressed design of the act: "In accordance with the obvious intent of the charter such a department will in due time be opened." A year later the Annual Report of the Regents states, "The organization of a medical faculty as a department of the University is under advisement." The Fourth Report of the Regents is more realistic in its analysis of the situation: "No steps have yet been taken toward the organization of the faculty of medicine, nor will the funds of the University, for some time to come, be adequate to its endowment." A further report followed the same vein.

With the intervention of the Medical Society of the State of Wisconsin at its annual session in Madison, January 16, 1850, the entire question of the establishment of the Medical Department of the University of Wisconsin was brought into sharp focus. "On motion, Doctors A. L. Castleman, E. B. Wolcott and James P. Whitney were made a committee to take into consideration the suggestions of Chancellor Lathrop in relation to the organization of the Medical Department of the University of Wisconsin; also all such matters connected with the subject of Medical Education as shall to them appear desirable, confer still further with the Regents of the University and report their doings in writing at the next meeting." When no progress resulted, apparently one of the committeemen, Dr. Erastus B. Wolcott of Milwaukee, took the occasion to attempt a transferal of the Medical Department to that city without success.

The present study concerns itself with the abortive effort of 1850 to 1857. Its course and fate are so linked with the personalities involved that no account of the period is adequate without some insight into their characters and capabilities. Unfortunately, the sources are limited and varied in relative

* From the University of Wisconsin Medical School. Read before the William Snow Miller Medical History Seminar.

** Chief Medical Director, Veterans Administration. Former dean, University of Wisconsin Medical School.

values. Few of the active participants in this worthy cause have left enough in the written word to afford perspective. Contemporary accounts of the principals are singularly sketchy and in certain instances entirely lacking. Yet from the bits and pieces of strangely diversified origin some idea, albeit hazy, of the first faculty of the Medical School of the University of Wisconsin may be drawn.

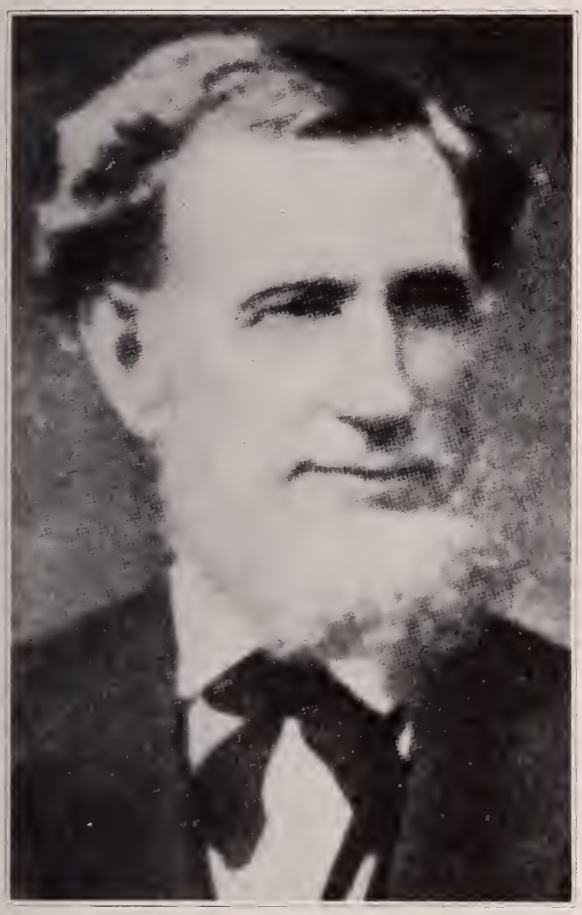

Fig. 1—Dr. Alfred L. Castleman

The most active figure in the movement to establish a Medical Department in the University of Wisconsin at Madison in the eighteen fifties was Dr. Alfred L. Castleman of Delafield. He is described as " a gentleman of distinguished abilities, highly cultivated, chivalrous, honorable, and of high and noble purposes and aims." As dean of the Medical Faculty and professor of the theory and practice of medicine, Castleman naturally led the ill-fated effort. Contemporary sources give a singularly confused picture of high resolve and clear vision thwarted by the uncertain times and political circumstances beyond his control.

Born in Kentucky in 1807, Castleman graduated from the Medical Institute of Louisville. In 1835 he came to Wisconsin to try his fortune in the Northwest Territory, which was attracting some of the more venturesome and enterprising young men of the land. Purchasing a farm near Delafield, he practiced there and in Milwaukee. His professional acceptance and growth are evinced by many casual references in the public press. Castleman was forthright in his support of his convictions. In 1849 he quieted the public turmoil attendant upon the epidemic of Asiatic cholera by the dangerous pronouncement, "Be assured that the disease *is not* contagious." He gratuitously compounded his error by assuming that it is "propagated by atmospheric causes." However, by 1866 Castleman had revised his opinion and openly contested Surgeon General Erastus B. Wolcott's position that cholera was not contagious. He was active in the professional circles of organized medicine; but neither the Milwaukee County Medical Society nor the Milwaukee City Medical Association, in whose foundation he participated, thrived at that time.

Doctor Castleman devoted a great deal of personal attention and time to the State Medical Society. As its president in 1849 and 1850, with the support of a few loyal friends he sedulously attempted to effect a repeal of the statutory restriction of membership in the State Medical Society. This clause of the charter to prevent "clogging Society with too large a number" was not rescinded until 1854. Contrary to expectations there was no early nor spontaneous enthusiasm on the part of the medical profession at large in the liberalization of membership, and the Civil War interrupted such activities completely for a time.

Nevertheless, President Castleman gave active leadership to three worthy causes that redound to his credit; *i.e.*, the eradication of quackery, the foundation of the Medical School, and the establishment of a State Lunatic Asylum. In a period when irregular practice was rampant in the new state and when every manner of practitioner was accepted at face value without reference to his qualifications and motivations, it required high courage to lead the fight against the forces of evil. To implement his end, Castle-

man appointed a committee, composed of one physician from each county, to report the names of all practitioners. Although the proposal indicated merely the designation of the educational background of such individuals, in June, 1850, the secretary reported very few returns. Some of these were unreliable, since, through inadvertence, non-society members and irregular practitioners had been named as committeemen and had afforded misleading information. Still Castleman persisted in his crusade by appointing a new committee. In spite of his valiant efforts and the occasional strong support of the lay press, the measure to control the quackery, patent medicines, and nostrums did not receive Legislative support.

In the present relation, Castleman's part in the effort to establish the Medical Department of the University of Wisconsin serves as a key to the entire problem. In 1850 Castleman was named by the State Medical Society to confer with Chancellor J. H. Lathrop in this matter. After due conference and consideration he conveyed to the Society the Chancellor's opinion that the finances of the University would not admit of the establishment of the Medical Department at that time.

The Seventh Annual Report of the Board of Regents contains the following action:

"The Board at their February (1854) meeting passed an ordinance establishing a Department of Medicine in the University. (The following chairs were announced.)

Anatomy and Physiology
Surgery—Clinical and Pathological
Theory and Practice of Medicine
Obstetrics and Diseases of Women and Children
Chemistry and Pharmacy
Materia Medica and Botany
Medical Jurisprudence

"The chairs will be filled at an early date.

"It is the fixed intention of the University authorities that all means at their command shall be so administered as to aid the diligent and successful student, and to secure to the institution a just public confidence and support.

"The medical Faculty shall hold their terms, and deliver their instructions in the town of Madison.

"Candidates for graduation—shall be not less than twenty-one years of age; shall be of good moral character; shall have had two years of private pupilage and have attended two courses of lectures or shall have attended three courses of lectures without previous pupilage (the last course in either case in this department); shall have passed a satisfactory examination, and, if required, shall have written and defended a thesis on some medical subject before the board of examiners.

"Candidates with the above qualifications, shall, on recommendation of the examiners, be entitled to the degree of M. D."

Another year passed without appropriate action to fulfill the avowed plan of 1854. The Annual Report for 1855 shows the following significant announcement:

"The Board at the last meeting (1854) provided for the organization of a Medical Department. The several chairs of instruction have been filled with the exception of those of Surgery and the Institutes of Medicine. Arrangements will be made for opening the school at an early day, and under favorable auspices.

"List of the Professors in the Faculty of Medicine:

Alfred L. Castleman, M. D., Professor of the Theory and Practice of Medicine
Ezra S. Carr, M. D., Professor of Chemistry and Pharmacy
D. C. Ayers, M. D., Professor of Obstetrics and Diseases of Women and Children
George D. Wilber, M. D., Professor of Materia Medica and Botany
Samuel W. Thayer, M. D., Professor of Anatomy"

With the supplementary Annual Report of 1856, as follows, the Medical Department seemed early assured:

"The several Chairs are now filled and the Faculty has been duly organized by the election of Professor A. L. Castleman, M. D., of Delafield, Dean; Professor Alexander Schue, M. D., of Madison, Treasurer; and Professor George D. Wilber, M. D., of Mineral Point, Secretary.

"As time will be necessary for prearrangements, the department will not be formally opened until early in the Spring of 1858; at which time regular courses of lectures will be commenced by the several Professors and systematic instruction will continue through a period of, at least, four months.

"If the main edifice is erected during the present year, the department will be opened there, otherwise a suitable building will be secured for temporary use."

The Faculty named by the Regents in 1855 and 1856 was completed by the following elections:

Joseph Hobbins, M. D., Professor of Surgery
Alexander Schue, M. D., Professor of the Institutes of Medicine and Pathological Anatomy
J. M. Lewis, M. D., Demonstrator of Anatomy

In recognition of his efforts on behalf of the Medical Department, the State Legislature of 1855 elected Castleman a Regent of the University. In 1856 the University of Wisconsin granted him the honorary degree of doctor of medicine. Doctor Castleman had spent untold energy and time in pursuit of his primary objectives, which successively

eluded him. His financial contribution exceeded $1,000. After protesting the obvious design of the University administration to supersede medical control of the proposed Medical Department, he resigned his nominal post rather than compromise his position. The Tenth Annual Report of the Board of Regents (1857) reads, "The opening of the University Schools of Law, and of Medicine, has been deferred by the Board till after the erection of the main edifice." This sentence historically bears an ominous portent. A half century was to pass before the Medical School became a functional unit of the University, and 70 years before the degree of doctor of medicine was granted to its first graduates!

The third goal of Castleman was to establish a proper state institution for the care of the insane. Governor William A. Barstow had initiated a movement with this objective. In 1854 the State Legislature passed an act creating a State Lunatic Asylum. Political opposition resulted in the repeal of this beneficent measure in the next session of the Legislature. Shortly thereafter (1856), Castleman, reporting to the Annual Session of the State Medical Society, stated there were 240 insane patients in the state. His committee proposed a change of title from "Lunatic Asylum" to "Hospital for the Insane." The support of the State Medical Society failed to persuade the Legislature, so the bill to create such a hospital was lost. Nevertheless, Castleman persisted in his efforts. His further moves were of a rather unusual nature. In essence he undertook to obtain a subsidy of $10,000 as a loan from the state, to which he proposed to add $25,000 of personal funds. With these monies, a site and the necessary buildings would be developed. Such an institution under his supervision would care for the insane patients in the state with preferential consideration for state over private applications. The legislators were not influenced by Castleman's strong representations of the economy and the other advantages of such an arrangement. The urgency of the situation had been brought home effectively, and an enabling act placed the control of the institution in a board of three commissioners. The State Hospital for the Insane began operations at Mendota three years later.

Castleman's political proclivities found ready outlets in that stormy period. In 1846, with certain stouthearted friends terming themselves "Unionists," he resisted strong forces that were striving to carve a new county outside Milwaukee. Unsuccessful in this effort, Castleman had attracted the public notice; and the following year (1847) found him an influential figure in the Second Constitutional Convention. However, he lost the nomination for Secretary of State on the Republican ticket. Nor was he able to recapture the early political promise in the postwar period. In a pathetic gesture in 1872 he called a reunion of the surviving members of the Second Constitutional Convention (1847).

As the specter of an internecine struggle over slavery arose over the land, Castleman took an active part in arousing public sentiment against the evil. With the onset of hostilities he joined the Fifth Wisconsin Volunteers as Regimental Surgeon. His journal of service is a revealing and intimate, if somewhat biased, reference source of the military medicine of the Army of the Potomac from July 31, 1861, to December 24, 1862. His service began at Camp Randall, June 19, 1861. The health of the troops in training was not good. One-third of their number were ill with measles, fevers, and diarrhea. The early movement to Camp Curtin near Harrisburg, Pennsylvania, afforded no improvement in sanitary conditions. The details of the movements and activities of the Fifth Wisconsin Volunteers may be taken as a fair cross section of the Army of the Potomac. The military affairs and fortunes of the army are not a primary concern of this study; but Castleman was an acute observer and many of his pungent commentaries are worthy of preservation. The officers of the line became a favorite target for his caustic notes. Commenting upon the interference of combat officers in medical affairs, he said that "they are about as well qualified to judge as would be so many of their mules." He wrote, "Since I came here, I think I can tell a man's calibre by his shoulder straps. The amount of brain is generally in inverse proportion to the size of his straps." Colonel Amasa Cobb of his own regiment drew this fire, "After we had been here five or six days, the Colonel was positively ignorant of the fact that we had a hospital on the ground, though there were three within fifty feet of his quarters, filled to their utmost capacity with the sick and suf-

fering." (August 8, 1861). His commanding officer continued to irritate Castleman, who protested against his interference with purely medical matters. The colonel charged Castleman with insubordination. The latter forthwith wrote an official letter requesting court-martial. This communication was ignored. Matters came to an unfortunate climax when the colonel ordered that none of the Regimental Surgeon's directions should be obeyed without his own sanction. Governor Alexander Randall's providential visit to the regiment afforded Castleman a responsive audience, and the unreasonable ban was lifted.

On one occasion Castleman observed (October 24, 1861): "A little skirmish today, amounting to almost nothing. A party of four or five hundred went out in the morning, came upon the enemy's pickets, and firing on them, drove them in. Then, on returning, our four or five hundred found five men in the field, drawing manure, and well armed with shovels and dung forks. We took them all prisoners, *without losing a man*! Wonder, if by tomorrow, this cannot be magnified into another 'Great Victory' to offset the terrible disaster at Edwards Ferry. This 'Grand Army of the Potomac' is a great field in which to win glory. Victories make glory, and victories with us are very cheap."

The presentation of a dress sword and belt to Castleman by the hospital attendants and patients brought the full wrath of the command on him. Charged with a detailed report of all contributors, he was further ordered to break all of these soldiers to the ranks and to return them to field units. Castleman refused to comply; but his appeal to the colonel was rejected. The transfer was made in the interest of the service. "The relationship of officers and soldiers is that of instruction and command on the one part, and of respect and obedience on the other." The replacements were very inadequate, and several serious mistakes by the dispenser led eventually to the return of his former aide as a hospital steward. Meanwhile Castleman had committed to his journal (March 10, 1862) this gem: "The last few weeks have taught me that in the army the Surgeon's duty is to take care of the Surgeon, and to leave conscience and humanity to take care of themselves." Apparently a rebuke from an officer of the line when Castleman offered assistance to a straggling soldier occasioned this bitterness.

As might be anticipated, the problem of supplies was especially trying to the physician turned Regimental Surgeon. On March 29, 1862, he wrote in a querulous frame of mind that "in the face of the enemy, expecting a battle, without a tent, an ambulance, a litter, a blanket, or a comfort for the wounded—not even a reliable nurse at my command. Well, I suppose all this is a small matter, so long as the commanders who brought it about are comfortable." Later he observed, "On examining the Steward's Department, I found *almost* nothing to feed the starving five hundred men on my hands —*absolutely* nothing *suitable* to feed them on; that for days there had not been a cooking utensil belonging to the hospital, for these five hundred sick, larger than a soldier's tin cup." (June 6, 1862). In the interest of improving the care of the sick and wounded, in a report to the Medical Director Castleman suggested the use of idle soldiers. This officer deemed the document a "piece of intolerable insolence, and as one good ground for my being dishonorably relieved." Whereupon Castleman committed the following sentiment to his journal (June 8, 1862): "They are from home, from family, from friends; they are suffering for want of the commonest attention; the dead and the dying are lying together for want of proper and sufficient aid to dispose of them otherwise. The living are dying for the want of the necessaries of life, which, in great abundance, are in sight, part owned by the government, part by the rebels; that owned by the latter carefully guarded by men withdrawn from our lines, lest some of these suffering sick should, in desperation, crawl from their beds, get in reach of, and take enough to snatch their languishing bodies from suffering, and perhaps from death. But worst of all, I have taken the liberty of stating these things plainly, and, as a penalty for my insolence in holding up a mirror to the eyes of a superior officer, I am to be relieved!"

The military camp is a fruitful field of rumor. Castleman wrote, "Munchausen must have been the legitimate son of a camp, or rather, the camp must be the legitimate progenitor of the whole race of Munchausen." Not only were the military plans wildly conjectured and projected, but the high command came in for its share of discussion and evaluation. General McClellan was a popular idol among the Federal soldiers even after

his military futility was widely suspected. Yet Castleman noted (September 1, 1861), "I wonder if Gen. McClellan does not need a rest to hold his glass steady whilst he looks at them." By December 3, 1861, he observed, "We are getting tired of McClellan's want of vim. How long is he going to be 'getting ready'?" This growing lack of confidence in McClellan is repeatedly reflected in the succeeding entries. When the Army of the Potomac took possession of Vienna, Virginia (March 15, 1862), he wrote, "I cannot look upon our possession of this place and the railroad without deeply feeling how much we have been outwitted. Here we have been held still with 150,000 to 200,000 men, since July last, by a little village mounting wooden guns. Poor McClellan, I fear a wooden gun will be the death of him yet, though his failure here may be attributable to the interference of others." When the spring of 1862 lengthened without military activity on McClellan's part (March 31, 1862), Castleman chafed, "The weather is beautiful, roads good, troops in fine condition, warm weather coming on, and here we are preparing as for a summer's stay. God help us and our little General, but put it into his heart not to remain here till the enemy, whom we have found, has time to fortify against our approach." The denouement followed: "General McClellan's command has dwindled down to three corps d'armée, and I regret to say that the opinion is beginning to be held by many, that he is not competent to the command of even this force." (April 10, 1862) By September 19, 1862, Castleman's reserve had broken all restraint. Referring to McClellan's failure to contain Lee's battered forces after Antietam, he said, "My own hopes that he would retrieve his lost character are all gone. I have lost all confidence. He can be nothing short of an imbecile, a coward, or a traitor." He completed his disdainful vein by saying that McClellan was "the best retreater in modern warfare."

Not all of Castleman's venom was vented on the commanding general of the Army of the Potomac. He made particular note of the foibles of Brigadier General Winfield S. Hancock. In the latter's 17 years of service, he averred, "Wherever he has been, he has certainly acquired a perfect intimacy with the whole gamut of profanity." On another occasion Hancock abused officers and men of his command who stopped to fill their canteens at a spring (August 19, 1862). In the riot of the Second Battle of Bull Run, Castleman recorded that Hancock refused to afford General Pope surgeons for the support of his overworked medical staff. By a singular coincidence, these serious charges against his immediate brigade commander are found in close relation to his estimate of an opponent (August 27, 1862): "I admire this man Jackson. He has snap in him, and deserves to succeed. Admiration of him, and of his energy, are unmistakable all through our lines. Our men are discouraged, disheartened, and constantly express the wish that they had such a General to lead them to honorable battle."

Most prophetic was Castleman's estimate of General Burnside (December 2, 1862), who succeeded McClellan in command of the Army of the Potomac: "When our new Commander (Burnside) started off, the wind whistled about our ears, under the great impetus which he gave his army, and so rapid was our progress that many expressed the hope that he would not prove only a quarter horse, instead of a thoroughbred turfster, with wind and bottom. The first heat was certainly run with great speed, but the length of rest between heats is out of all proportion to the length of the race."

Castleman railed against the wanton destruction of private property and the uncontrolled looting by the Federal troops. His occasional social engagements with civilians of Southern sympathies were cherished memories. He observed, "Alas! Poor Virginia! Your revenues are cut off, your industry paralysed, your soil desecrated, your families in exile, your prestige gone forever."

Fortuitously, he observed two military developments of epochal importance. He twice noted balloon ascensions by Professor Lowe to observe Confederate fortifications (April 11 and May 23, 1862). His account of the Monitor is very graphic: "A raft—an iron raft, about two hundred feet long, lying from eighteen to thirty inches above the water, with its great cheese box on one end, with holes in it to shoot from. Were I to attempt a description, I should say it looked for all the world just like the sole of an immense stoga boot lying flat on the water with the heel sticking up."

Castleman was deeply interested in the health of the Fifth Wisconsin Volunteers.

He was meticulous in his attention to the details of sanitation in the light of his period, and many notes were devoted to these activities. Wisely he noted (October 1–2, 1861), "I am fast coming to the conclusion that the great mortality of camp life is owing more to neglect of the proper means within our reach of preserving health, than to any exposures to which the soldier is peculiarly liable." With commendable pride Castleman outlined his plan of simple hygienic routine (December 5, 1861): "It is now six days since I resumed the charge of the hygiene of the camp. My first work was to have my tent struck and removed from the ground, that the spot on which it stood might be thoroughly scoured and cleaned. I then had the whole sprinkled with disinfectants. Have daily visited every tent since to see that it was ventilated, by having the bottoms turned up for an hour or two, and that it was well cleaned. The result has been most striking. The sick list has already, in only six days, decreased fifty in number, though the seeds of typhus, sown some time since, still sprout, and occasionally give us serious trouble." With acerbity this alert Regimental Surgeon took exception to the prevalent theories of the responsibility of foul air for hospital infections and typhoid fever. He committed to his notes the following: " 'Twas a gangrene of the mind, for want of free ventilation of the brain."

Castleman's appreciation of the psychology of the sick and wounded soldiers is witnessed by this quotation (January 2, 1862): "There is no disease so contagious, or so depressing to vital energy when taken, as inactivity and gloominess of mind. Introduce one such temperament into your hospital, without an accompanying antidote, and the condition will be communicated to all others in the hospitals, with as much certainty, and with greater rapidity, than would be the infection of small-pox or measles. Let the admission of such a patient be accompanied by the presence of a long, sour-faced hospital steward who keeps in the hospital tent a table covered with cups, and spoons, and vials, and pill boxes, and syringes, and who mingles with every potion he gives a homily on hospital sickness, on fatality in the army, on the number of deaths from typhoid in the kept tent, and my word or observation for it, though the breezes of that hospital come fresh 'from Greenland's icy mountain', they will be freighted with the mephitic vapors of hospital fever and gangrene." Conversely, Castleman cited the beneficence of cheer in the surgeon and the attendants. He objected to the presence of nurses in the field, but believed them essential in base hospitals. Further he stated, "Since I have been in the army, I have lost all dread of the much-talked-of foul air of hospitals, *only so far as it is difficult to correct the mental atmosphere about it.*"

Early in his military career Castleman was persuaded to join his fellow surgeons in opposing the United States Sanitary Commission. The cabal had gathered in Castleman's tent to frame their formal protest when they were called to dress some casualties. The supplies made available by the bemeaned Commission gave pause to their resolution. Repeated references to his growing appreciation of this voluntary effort appear in the dairy. Characteristic was the experience at Antietam (September 18, 1862): "Our wounded suffered much for want of chloroform. I think that not over three or four surgeons on the field had a supply. I saw but two who had. Why will surgeons permit themselves on a campaign like this to be without the necessary articles of comfort for the wounded? The few pounds on hand were exhausted in less than three hours. The men lay suffering from their wounds, and in many instances surgeons were operating without it. Government teams had not come up. What could we do? In this dilemma, at the very right moment, in stepped Mrs. Harris, of Philadelphia, with the announcement that she had just arrived with twenty pounds of chloroform from the U. S. Sanitary Commission. What an angel of mercy is this Mrs. Harris! What a source of ever-present comfort and well-directed effort is that Sanitary Commission! The soldiers of this army will have cause of prayer for it in their living and in their dying hours."

Castleman's resignation from the army was accepted December 24, 1862. He did not long remain inactive in his nation's cause. In 1863 he joined the Sanitary Commission. Assigned to the Army of the Cumberland, he was captured by the Confederates. When his medical duties as a civilian were explained, he was returned to the Union lines.

From the diary one gathers that recurrent illnesses, diarrhea, dysentery, and malaria had greatly debilitated Castleman dur-

ing his service in the Army of the Potomac. He served as marine surgeon in Milwaukee during the postwar period, but much of the fire that had made him a public figure before the war was gone. In 1857 he had purchased the sanitarium on Lake Monona, but there is no record of his personal attendance upon the same. Apparently he had some plans to substitute this institution for the proposed State Hospital for the Insane. When the Legislature made independent provisions for these patients at Mendota, Castleman was deprived of the natural source of support for his private venture. His comings and goings were less frequently noted in the press. He observed in a letter to the local newspaper that the "fogies of the older times are being elbowed out and aside by Young America." In 1873 he moved to California in the hope of improving his failing health. He died at Oakland on August 22, 1877.

(To be continued in the September issue of the Journal.)

Fall Circuit Programs Announced

September

Tuesday, the 13th: St. Agnes Nursing School, Fond du Lac
Wednesday, the 14th: Wausau Club, Wausau
Thursday, the 15th: Elks Club, Portage

SURGICAL EMERGENCIES: Geo. E. Collentine, Jr., M. D., Milwaukee

NUTRITION AND INFECTION IN CHILDHOOD: Joseph A Johnston, M. D., Detroit

VAGINAL HEADACHES (Manikin Demonstration): Thomas W. McElin, M. D., Chicago

CORONARY HEART DISEASE: George G. Rowe, M. D., Madison

October

Tuesday, the 18th: Elks Club, Rice Lake
Wednesday, the 19th: Mead Hotel, Wisconsin Rapids
Thursday, the 20th: Elks Club, Appleton

CURRENT TREATMENT OF SYSTEMIC ARTERIAL HYPERTENSION: James W. Culbertson, M. D., Iowa City

SURGICAL EMERGENCIES IN CHILDREN: Kenneth Lemmer, M. D., Madison

ABORTIONS AND CHRONIC DISEASES RELATED TO OB: William C. Keettel, M. D., Iowa City

POISON CONTROL: Franklin J. Mellencamp, M. D., Milwaukee

CREDIT FOR A. A. G. P. MEMBERS: 5 hours of *formal* teaching credit for each meeting.

Cost: $6.00, including dinner and "coffee break" in middle of afternoon program.

To assist with proper meal planning, please send your reservation to the State Medical Society (Box 1109, Madison) immediately. Make your check payable to the State Medical Society of Wisconsin and indicate which clinic you will attend.

[OTHER CIRCUITS IN JANUARY *(Richland Center, Oconomowoc, and Sheboygan)* AND IN FEBRUARY *(Janesville, Stevens Point, and Green Bay)*]

Sanitation in Unincorporated Residential Areas

As It Looks to Your State Board of Health

THROUGH advancement of science and research the fundamental solutions to most sanitary problems can be ultimately realized. However, the complexities that occur in our environment often make them difficult to apply. An example of one such complexity is the change from city dwelling to rural city dwelling. It has created a major unsolved sanitary problem—what can be done to obtain sanitary disposal of sewage in the unincorporated residential "fringe" areas?

The city dweller previously had his household sewer connected to a municipal system for central scientific treatment, but he lost "sewer-rights" upon leaving the community. He was confronted with installation of a private system. All too often soil conditions were subsequently found to be unsuitable for absorption of the septic tank effluent, and building lots inadequate in area to materially increase absorption facilities. The "country" area became crowded with other rural-city dwellers. Thus began the era of neighbor complaining about neighbor and of nuisances and public health hazards created by overflowing seepage pits, sewage flowing in roadside ditches, into dry runs, or into farm drainage tile and storm sewer systems.

The solution of this unincorporated residential area problem requires more than sanitary engineering application. This is a modern problem requiring teamwork with the people in the community, for in this specific field there is real need for means by which townships and unincorporated communities can finance a prime health objective —sanitary disposal of sewage.

The same kind of teamwork is essential for the solution and control of other sanitary problems characteristic of the unincorporated residential environment. These health dangers, hazards, and nuisances can include: pooling of stagnant waters caused by ineffectual storm and other surface water drainage; lack of systematic garbage and refuse collection and disposal; rodent and insect infestations which result from the inadequacy of sanitation of the environment; and the usual nonexistence of area planning, zoning, or enactment of proper building codes in the early stages of the residential development.

The remedy for these sanitary problems is not a matter of awaiting development of basic sanitation knowledge. It is, rather, the need for joint action to advance and extend familiar services.

To a very considerable extent, legislative and administrative bodies in Wisconsin have met certain current needs. The metropolitan sewerage district and town sanitary district laws together with sanitary fundamentals have permitted the extension of familiar services. A more positive concept, though, must be worked out for those who, upon learning of the added taxation and/or service charges to be assessed within the district, refuse to join forces to form the teamwork that will eliminate the hazard to health. It is surprising to note the number of rural-city dwellers who will continue to choose insanitary conditions in lieu of the service charge or tax necessary to proceed with engineering works that will assure their correction. The Board of Health has suggested to the present legislature methods for the formation of sanitary districts when the people within the problem area refuse to proceed.

Basic knowledge, of course, is still needed in the control of infectious disease. But of equal and probably greater importance today in the solution of sanitary problems in the unincorporated residential areas is the need for close collaboration of the public, public health engineers, and members of other services, including the lawmaking bodies. — H. E. WIRTH, *Assistant State Sanitary Engineer.*

HEALTH FILMS

Nearly 400 titles of sound movies, sound and silent filmstrips, and transcriptions on health are included in the 1955 edition of *Health Films.* Subjects include mental health, nutrition, dental care, heart disease, cancer, sex education, home safety, and others.

All of these aids may be borrowed by residents of Wisconsin without charge from the Film Library, State Board of Health, Madison 2.

THE MEDICAL FORUM

SOCIETY REVIEWS ACHIEVEMENTS OF 1955 LEGISLATURE

Cultists Unleash Full Fury on Fluoridation, But Coup Flops

Madison, Aug. 1. — Quacks and cultists made a determined and successful bid for publicity during the legislative session, but came out on the short end of accomplishment.

They hitched their noisy wagon to the anti-fluoridation star by supporting bill 457, A. to prohibit the State Board of Health from advocating the use of fluorides in drinking water.

Apparently emboldened by their recent successes in defeating local fluoridation referenda, the cultists hoped for a coup that would stifle health progress by stifling public health administrators.

The bill was referred to the Assembly Committee on Agriculture. Despite the attention-getting campaign of the Wisconsin Chiropractic Association and a bevy of "natural health" faddists, the proposal never really got off the ground.

DR. SULLIVAN
Chairman of Public Policy Committee

CHIROS REPORT

At a public hearing on April 27, there was more argument about the merits of fluoridation than about the bill itself. Attorney John E. Reilly, Wauwatosa, registered in favor of the ban on the Board of Health on behalf of the Wisconsin Chiropractic Association.

Almost all of the appearances for the bill were by representatives of anti-fluoridation groups which are notably instigated or supported by chiropractors. Alex Wallace of Stevens Point called fluorides "the backbone of rat poison," while others considered it "socialistic mass medication." On the other hand, M. Starr Nichols, Ph.D., of the State Laboratory of Hygiene, said he was convinced that fluoridation "is one of the greatest advances in dental health the world has ever known." Representatives of the State Medical Society, State Dental Society, State Board of Health and several committees for fluoridation appeared against the bill.

The attempts to stifle the Board of Health in its promotion of the fluoridation project came primarily from representatives of the Wisconsin Natural Health Association and anti-fluoridation committees. Most of the 75 persons who registered in favor of the bill were from Monroe, Kenosha, Sheboygan or Chippewa Falls. One was from Atlanta, Georgia, and many were chiropractors or relatives of chiropractors.

The State Medical Society and the State Dental Society had the support of the Wisconsin Congress of Parents and Teachers and the League of Wisconsin Municipalities in opposition to the bill.

The result of all this anti-scientific falderal—indefinite postponement.

See last page of Forum for important action on Board of Health

Madison, Aug. 1.—Several major accomplishments in the field of public health protection and improvement can be attributed to the efforts of the State Medical Society during the past legislative session.

Although the current legislative session is in recess until October 4, the majority of the bills related to medicine and public health have received final action of some kind.

Probably the most significant and far-reaching legislation of direct concern to the medical profession is the passage of the revised commitment laws for the mentally diseased. This program was initiated nearly two years ago under the direction of the Society's Commission on State Departments, and its Subcommittee on Commitment Laws has been directly concerned with the matter in cooperation with the county judges.

SUPPORT CHILDREN'S CODE

Not only does this action streamline commitment procedures, but it effects a seriously needed humanization of the statutes in regard to the mentally diseased. More than that, it releases the epileptic from the stigma of insanity or mental incompetence.

The Society can also take pride in its support of the revised Children's Code. This revision is being hailed in Wisconsin and even nationally as one of the most significant steps in recent years in the handling of children and youth.

Once again, the Society has had to work vigorously in the interest of the public by beating down the efforts of quacks and cultists to interfere with the promotion of better health through the application of scientific achievement and to protect the public from ill-advised and unprincipled healing methods.

In the periods between legislative sessions and throughout the active sessions of the Assembly and the Senate, the Committee on Public Policy of the State Medical Society has contributed a tremendous amount of time, effort, and

(Continued on page 394)

THREE PHARMACY BILLS KILLED; COMMITTEE TO STUDY

Madison, Aug. 1.—A special committee was named to see if it could salvage the intent of three bills relating to dangerous drugs and narcotics. The three measures were introduced or supported by the Wisconsin Pharmaceutical Association.

The legislature killed three major bills on this subject and turned the matter over to a conference group to "propose new legislation if advisable." This group will meet September 20.

SMS ADVICE ASKED

The three "dead" bills are as follows:

262, A. proposed to add thousands of drugs to the prescription list by labeling as "dangerous drugs" any drugs unsafe for self-medication, and bearing the legend, "Caution—Federal law prohibits dispensing without a prescription," and any designated by the State Board of Pharmacy as unsafe for self-medication after a public hearing determined such fact.

266, A., introduced by the Wisconsin Pharmaceutical Association, would have substantially amended the uniform narcotic laws of Wisconsin. It proposed to allow a pharmacist, without a written prescription, to sell, dispense or distribute narcotic drugs, a combination of the narcotic drug found to possess relatively little or no addiction liability by the United States Commissioner of Narcotics, and paregoric. It would have required only that a pharmacist have an oral prescription for these narcotics from a physician, dentist or veterinarian. The pharmacist would subsequently reduce the prescription to writing. In addition, the bill provided that the enumerated medical preparations were to be sold at retail only by a registered pharmacist.

87, S., supported by the pharmacy association, substantially altered the definition of narcotic drugs and would have caused considerable confusion, both for physicians and law enforcement agencies.

During the course of studying these bills, it became apparent to the legislature that the bills might upset the entire legal structure of the state narcotic laws.

The legislature directed, in joint resolution 95, S., that "the State Board of Health and the attorney general are requested to consider the adequacy of present statutory definitions of narcotics and dangerous drugs and the exceptions therefrom and that in connection with the study they be authorized to consult with the Wisconsin State Board of Pharmacy, the State Board of Medical Examiners and others for such technical advice as they might not otherwise possess."

The State Medical Society has been invited to participate in the discussions on the entire matter.

BILLS "VAGUE"

The State Board of Health and the attorney general are requested to report their findings jointly to the legislature at its adjourned fall session, together with proposed new legislation, if advisable.

The joint resolution pointed out that the bills are "vague and uncertain in terms and have delegated the responsibility to federal bureaus and officials so as to cast serious doubts upon the validity of the proposals."

The legislature felt that it is a matter of "utmost concern to public health and safety that the definitions of both narcotics and dangerous drugs be inclusive, precise and abreast of modern pharmaceutical developments."

Bill Ends Reporting of Epilepsy by M.D.'s

Madison, Aug. 1.—Physicians are no longer required to report epilepsy to local health officers. This relief in reporting requirements came through the passage of bill 322, S. with the support of the State Medical Society.

The change is made possible by scientific advances which virtually assure medical control of the epileptic. Originally, the reporting requirement was developed as a means of controlling epileptic drivers. Now driver's licenses will be issued to epileptics, providing the afflicted person is under medical control and periodic review.

Relax Requirement of Citizenship for Some Physicians

Madison, Aug. 1.—Citizenship requirements have been waived for the emergency employment of physicians in state mental institutions.

This change came about as a result of the passage of bill 82, S., introduced at the request of the Department of Public Welfare. It developed out of the difficulties of the department to obtain physicians for service in the mental institutions under its jurisdiction.

The statutes have been amended to read that "upon certification of the director of public welfare to the director of personnel that a critical need for physicians exists in state mental institutions, the director of personnel may open examinations to licensed physicians without regard to residence or citizenship."

Legislature OK's City Plan for New Street Near Society Office

Madison, Aug. 1.—The State Medical Society will benefit indirectly from the effort of the city of Madison to extend and improve its street system.

City planning for the future involves an expansion of the street network on the south side, where the State Medical Society's new building is located.

DIRECT TO SQUARE

The legislature approved the city's proposal (276, A.) that a street be constructed across Lake Monona directly adjacent to the Chicago & Northwestern and Chicago, Milwaukee, St. Paul & Pacific railroad tracks, which also cross Lake Monona on the west side of the lake near Law and Brittingham parks.

The construction is subject to approval by the Public Service Commission. If it becomes a reality, the new street will cut the distance from the Society's offices to the Square by almost a mile and bring a direct route to and from the downtown area to within one and a half blocks of the office.

Board of Health Seeks State Authority for Programs

Governor Vetoes TB Bill, But Program Continues

Madison, Aug. 1.—A bill to obtain specific state authority to conduct a TB case finding program in the State Board of Health was vetoed by Governor Kohler on the basis that the board already has sufficient powers for the continued operation of the program.

Although the bill was introduced at the request of the State Medical Society, it later became clear that the Board of Health could maintain TB projects under existing legislation.

The problem was somewhat akin to that in the industrial health program of the board described in the adjoining column. However, in the case of tuberculosis, the board operates the program through categorical grants which provide reasonable assurance of continuation.

Industrial hygiene, on the other hand, is operated out of general funds which fluctuate in amount and purpose. Other public health activities may have such seniority and popularity as to result in the elimination of the little-known but vital industrial health projects.

Okay Operation of Industrial Health Program by Board

Madison, Aug. 1.—Both houses approved a State Board of Health bill (558, A.) which seeks a state mandate to operate an industrial health program. The State Medical Society gave full support to the measure.

Prior to this session, the State Board of Health got its authority to operate an industrial hygiene program from general power granted by the state. However, there was no assurance that the program would be continued if money for the state's general funds were not sufficient for its operation.

The bill requires the Board to operate a division on industrial health to make studies on the exposure of employees to toxic materials and health hazards in Wisconsin industry. It requires that the division advise management on control or elimination of potential health hazards and aid in the establishment and improvement of plant medical and nursing programs.

New Civil Defense Law Affects Every Town and Village

Madison, Aug. 1.—Governor Kohler has signed into law new civil defense legislation making it mandatory for every town, village, city and county to have a civil defense organization.

Under the new law, the governing body of towns, villages and cities must establish a civil defense organization with a director; provide an attack warning system; take part in test exercises on request; and use its resources to the fullest in an emergency.

County boards must appoint civil defense coordinators to serve as liaison with municipalities in the county in integrating their activities at the county level and to integrate the county into state plans. Every municipality and county may levy taxes and make appropriations for civil defense purposes.

In carrying out the provisions of the new law, the state and every municipality shall utilize so far as possible the services, equipment, supplies and facilities of existing agencies.

Civil defense workers are covered by workmen's compensation when they are enrolled in a recognized civil defense unit.

Included in the civil defense plans under the new law are programs involving preparations for handling medical and health emergencies.

To provide local public administrators with an explanation of their responsibility under the new law, the State Office of Civil Defense has been holding a series of 14 one-day institutes throughout the state. Additional details will be mailed to local administrators by the State Office of Civil Defense.

The entire state and local program is under the over-all direction of the Governor.

GOVERNOR VETOES BLOOD TYPE BILL

Madison, Aug. 1.—The Society successfully opposed the plan to require that every driver's license contain a space for the driver's blood type. Although passed by both houses, the Governor vetoed the bill (165, S.).

Governor Kohler, in his veto, recognized the importance of blood typing in adequate medical care but said that the driver's license is not the place for the information. The applicant, in understandable ignorance, may indicate the wrong blood type or may not carry his own card. If a physician accepted the blood type as reliable under these circumstances, the Governor pointed out the card might very well contribute to needless death.

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LEGISLATURE ADOPTS SMS BILL ON COMMITMENTS

Madison, Aug. 1.—Wisconsin took a notable step forward in the humane treatment of mentally diseased persons when the legislature adopted bill 291, S.

The bill represents the long-term efforts of the Division on Nervous and Mental Diseases of the Commission on State Departments of the State Medical Society. A subcommittee headed by Dr. Keith M. Keane, Sheboygan, worked with representatives of the Department of Public Welfare and the Wisconsin County Judges Association to perfect the changes for the commitment of the mentally diseased.

SMS TO INTERPRET

Of fundamental importance is the fact that the bill eliminates the term "epileptic" from chapter 51 of the Wisconsin Statutes. It is the purpose of this chapter to provide for care and treatment in state and county hospitals for persons who by reason of mental disease are in need of care and treatment not feasible in their own homes or in private facilities.

Among the accomplishments of the bill are the following:

1. Specific provision is made for the more humane detention of mentally diseased persons under temporary custody in local jails. Temporary detention is to be in a hospital where there are suitable psychiatric facilities or, if there is no such hospital in the county, in a place of temporary detention until arrangements can be made for transportation to a facility where such services are available. If a facility other than a hospital is used, the patient should be under the care of a physician during the period of temporary detention.
2. A great deal of objectionable terminology such as "lunacy" is eliminated from the chapter.
3. Medical examinations of persons where commitment is sought may now be conducted in physicians' offices or other appropriate places rather than in open court.
4. The bill provides for more adequate medical fees and permits a physician to charge for his examinations of the patient rather than solely for his appearance in court.
5. The bill also makes some dozens of other important changes which are designed to streamline and humanize commitment procedures.

DR. KEANE

The subcommittee of the State Medical Society which developed the program was composed of the following physicians: Keith Keane, Sheboygan, chairman; Walter Urben, Madison; J. T. Petersik, Winnebago; Owen Clark, Oconomowoc; Henry Veit, Milwaukee; Roland Jefferson, Milwaukee; Michael Kasak, Wauwatosa; and E. D. Schwade, Milwaukee.

The law specifies that one of the physicians appointed by the judge to examine a patient in the category of the mentally ill shall, if available, be a physician with special training in psychiatry. The law also removes terminology from the statutes that suggested that a person lost his civil rights by commitment to a hospital.

The Society, through the Commission on State Departments, intends to implement the passage of the bill with a medical interpretation of the bill to practicing lawyers and county judges. The medical profession's problems and recommendations in the administration of chapter 51 will be explained to those who have the most opportunity to come in contact with the mentally diseased.

MR. SCHMIDT

Welfare Department Acts Quickly on Epileptic Cases

Madison, Aug. 2.—The State Department of Public Welfare has taken immediate action to exclude epileptics from the category of mentally ill, mentally infirm and mentally deficient as a result of the enactment of bill 291, S.

Wilbur J. Schmidt, director of the department, announced that "patients committed or voluntarily admitted *solely* as epileptic and who are diagnosed as being without mental illness, mental infirmity or mental deficiency must be discharged as soon as possible."

He said that arrangements should be made at once with the patients' relatives, guardians, sponsors, relief agencies, county homes, or other resources to receive such patients as are unable to maintain themselves. Patients who are already on placement cannot be returned to the institutions.

Patients committed or voluntarily admitted solely as epileptic but who are diagnosed as also being mentally ill, mentally infirm or mentally deficient should be recommitted according to appropriate commitment procedures for the mentally diseased.

No new patients may be committed or admitted solely as epileptic to the colonies, state or county mental hospitals. This applies, Mr. Schmidt said, only to patients under the State Mental Health Act and does not apply to persons under charge or conviction of crime.

Society Has Major Role in Improving Nursing Legislation

Madison, Aug. 1.—Two significant nursing bills were adopted by the legislature, but only after substantial revision and improvement prompted by the State Medical Socity in recognition of some of the actualities of the nursing problem.

Bills 196, S. and 411, S. create for the first time statutory definitions of professional nursing and practical nursing and revise the prerequisites for examination and the reasons for suspension or revocation of license.

DEFINE NURSING

Considerable negotiations were carried on with hospital and nursing groups relative to 196, S., a bill sponsored by the State Board of Nursing. It is summarized as follows:

1. The original bill attempted to establish what constituted cause for revocation or suspension of certification or license for either TPN's or RN's. One of the causes was "unprofessional conduct." Since TPN's are not regarded as professional nurses, their certification could hardly be withdrawn for unprofessional conduct.
2. One of the requirements for certification of a TPN is completion of a course in "an accredited school for trained practical nurses approved by the board." The board may now waive the schooling requirement if it feels the applicant has had comparable training by virtue of experience in actual practice. In the first draft of the bill, the nursing board sought to terminate that discretion and limit applicants only to those who have attended recognized schools.

In reference to bill 411, S., proposed by the Wisconsin State Nurses Association, the Society made strenuous and successful efforts to improve proposed definitions of RN's and TPN's:

1. The bill sets up a statutory definition of the practice of the professional nurse as "the performance for compensation of any act in the observation or care of the ill, injured or infirm, or for the maintenance of health or prevention of illness of others, which act requires substantial nursing skill, knowledge or training, or application of nursing principles based on biological, physical and social sciences, such as the supervision of a patient, the observation and recording of symptoms and reactions, the execution of procedures and techniques in the treatment of the sick under the general or special supervision or direction of a physician, the execution of general nursing procedures and techniques and the supervision and direction of trained practical nurses and less skilled assistants."

   Persons who are not registered may not legally practice professional nursing or use any title to indicate that they are registered or professional nurses.
2. As originally written, the definition of professional nursing above would have permitted the nurse to practice various medical procedures and techniques independent of the physician.
3. For the first time, the statute clearly states that "no license is required for practical nursing." But it also points out that no person without a license shall hold herself out as a trained practical nurse or licensed attendant in any way.
4. The new statute defines the practice of practical nursing to mean "the performance of any simple acts in the care of convalescent, subacutely or chronically ill, injured or infirm persons, or of any act or procedure in the care of the more acutely ill, injured or infirm under the specific direction of a nurse or physician. A simple act is one which does not require any substantial nursing skill, knowledge, or training, or the application of nursing principles based on biological, physical or social sciences, or the understanding of cause and effect in such acts."

The Society also brought about revision of the original bill to relieve the unlicensed practical nurse of possible economic sanctions. At one time, the bill provided that no court action could be brought after January 1, 1956, to recover compensation for professional or trained practical nursing services unless, at the time such services were rendered, the person providing the services was a registered nurse or a licensed trained TPN.

Bill Redefines Chiropody Practice

Madison, Aug. 1.—An attempt to clarify the definition of chiropody won legislative approval.

Under the new law, chiropodists are not permitted to perform cutting operations "directed primarily towards the treatment or correction of afflictions of the bones, ligaments, muscles, nerves, or tendons of the feet."

This is an expansion of the previous definition which did not permit cutting operations "involving the bones, ligaments, muscles, nerves, or tendons of the feet."

The Society took no legislative position on the bill.

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SMS PLAN FOR MEDICAL EXAMINERS SYSTEM STILL ALIVE

Madison, Aug. 1.—A State Medical Society effort to end Wisconsin's obsolete coroner system for the taking of inquests made notable headway during the recent legislative session. Although not passed, the merits of the proposal were well recognized.

The mortality investigation system proposed by the State Medical Society (434, A.) in cooperation with the Wisconsin Chiefs of Police Association, the Wisconsin State Bar Association, and the Wisconsin Funeral Directors Association has been turned over to the Legislative Council for study to determine how it can be financed.

In joint resolution 114, A., the legislature pointed out that "an accurate determination of the cause of mysterious and reportable deaths is of critical importance, not only in the detection and suppression of crime, but also in the establishment of civil rights resulting from deaths allegedly caused by industrial accidents, automobile collisions and other causes."

REPORT IN 1957

It called attention, also, to a study concluded by the Wisconsin Legislative Reference Library in early 1955 disclosing that substantially less than one half of those Wisconsin officials charged with the responsibility of making such important scientific determinations were in any way qualified to do so.

The same resolution termed this situation a "grievous deficiency" but pointed out that, although bill 434, A. was recommended for passage by the Assembly Committee on State Affairs, "there remain unresolved questions as to how the legislation should most effectively be implemented, financed and established." The Legislative Council will conduct its study and report its findings and recommendations to the 1957 legislature at the opening of its regular session.

The proposed medical examiners system represents an attempt at modernization of the state's system of determining the cause of mysterious and reportable deaths. It would be a substitute for the inquest duties of coroners.

The system would be mandatory upon each county or group of contiguous counties. Each such unit would have an M. D. appointed as county medical examiner on a full or part-time basis. His compensation is still to be determined.

The county medical examiner would be required to conduct an inquiry into the cause of all deaths in which there are unexplained, unusual or suspicious circumstances; homicide; suicide; deaths following an abortion; deaths due to poisoning, whether homicidal, suicidal, or accidental; deaths following accidents; deaths where there is no physician or attendant; and deaths in which a physician refuses to sign the death certificate.

SYSTEM BADLY NEEDED

The county medical examiner could call upon the State Department of Mortality Investigation, also established by the bill, for assistance in any areas where it was needed. The bill also prescribes the records to be kept by the examiner, cooperation to be given him by all law enforcement officials, and his relations to the district attorney.

The State Mortality Investigation Department would be created to maintain laboratories equipped with all medical and scientific equipment necessary to aid the county examiner. The department would be governed by a board of seven members, including the deans of the University and Marquette schools of medicine and law or faculty members named by them.

Studies have revealed that medical participation is less effective in America in administration of justice than in any other country in the world. As a result, the improper handling of mysterious and wrongful deaths may result in nonrecognition of murder, the unjust accusation of the innocent, improper evaluation of medical evidence, failure to acquire medical evidence for criminal and civil cases, ignorance of certain causes of death that might be prevented, and impairment of the value of vital statistics.

Coroner Is Outmoded; Professional Men Are Needed

The Milwaukee Journal in an editorial March 20, 1955, had this to say about the proposed medical examiners system:

"The coroner system is grossly ineffective. It does not now offer even reasonable assurance that such investigation will be made, as a matter of course.

"It would be harder to patch up the decrepit, outmoded coroner system than to inaugurate the new medical examiner system, long tested and proved. It has been talked over for years, long enough so that it ought to be done now without further hesitance."

TEMPORARY LICENSE OKAYED FOR M.D.'S

Madison, Aug. 1.—Communities or institutions with emergency needs for medical personnel may get substantial assistance from the passage of a State Medical Society-sponsored bill providing for temporary licensure of physicians.

The passage of bill 512, A. permits the State Board of Medical Examiners to issue a temporary license to practice medicine and surgery in a particular community or institution which has a specific emergency need for medical personnel.

Because the Board of Examiners normally meets only quarterly, there have been circumstances in which communities or institutions have had a dire need for a physician but were forced to wait until the next examination date before the interested physician could receive his license and establish practice.

LOSE INTEREST

On some occasions the physicians who were forced to wait until the examination date lost interest in the location, and the community or institution was unable to find a replacement.

The new law provides that the temporary license will expire 30 days after the applicant has been granted a license or on the date that the Board determines the applicant is qualified for regular license. Under no circumstances shall a temporary license be issued more than once to the same person.

Wisconsin's 1955–1957 state legislative council at its initial meeting in the capitol. Seated (left to right), Assemblyman LaFave, Senator Rogan, Assemblyman Marotz (secretary), Senator Panzer (chairman), Assemblyman Catlin (vice-chairman) and Assemblyman Molinaro. Standing (left to right), Earl Sachse (executive secretary), Senator Porter, Assemblymen Ryczek, Ludvigsen, Abraham, Senator Clark, Assemblyman Bakke and Senator Miller. Senator Franke and Assemblyman Toepel were absent.

Society Has Role in Adoption of Revised Children's Code

Madison, Aug. 1.—Governor Kohler in a message to the legislature on June 24, 1955, said, "I am frank to say that, had this legislature done no more than enact two bills—the Children's Code and the measure providing for construction of a new industrial school for boys—it could have adjourned with a feeling of pride and satisfaction."

The State Medical Society of Wisconsin shares in that pride to the extent that it has participated in the preparation and support of the new Children's Code.

The code embodied in bill 444, S. was the result of one and a half years of study by the Legislative Council's Child Welfare Committee. This is the first recodification of child welfare laws in Wisconsin since 1929.

COVERS ADOPTIONS

The provisions of the new Children's Code delete obsolete provisions, simplify and modernize language, eliminate repetition, and thus make the law easier to understand. There is now a more orderly sequence of procedures and provisions of the laws affecting children and youth.

The new code covers areas relating to:

1. Organization and administration of the juvenile court.
2. The detention of children.
3. A clearer statement of the responsibilities of both local and state governmental agencies relating to child welfare services and the provision of such services to the juvenile court.
4. Licensing procedures of the State Department of Public Welfare affecting voluntary child welfare agencies, day care centers and foster homes.
5. Community services for the prevention of delinquency.
6. Clarification of juvenile court jurisdiction for children alleged to be delinquent.
7. Provision for court review in adoption cases when a guardian has denied consent.
8. Substantial changes in the procedures for adoptions.

No doubt, one of the most important aspects of the Children's Code for physicians is that part relating to adoptions. Among other things, the new code effects some changes concerning the age of petitioners for adoption, the consent of parents, court review of the guardian's refusal to consent, withdrawal of consent, appointment of investigators for the court in adoption cases, the ability of the adopted child to inherit from natural parents, and questions concerning interstate placements.

The Child Welfare Committee of the Legislative Council, which submitted the bill, was composed of nine members — three assemblymen, three senators and three outstanding citizens. The committee made extensive use of an advisory committee of the juvenile court judges and social agency experts, as well as officials and staffs of various state departments and voluntary agencies. There were over 42 meetings, which included eight public hearings held in eight different sections of the state.

Board Secretary to Serve on State Grievance Committee

Madison, Aug. 1.—The State Medical Society assisted the State Board of Medical Examiners in its effort to refine the Medical Practice Act.

The Board introduced bill 511, A., providing that the secretary rather than the president of the Board serve as a member of the State Medical Grievance Committee. Other members of the committee are the state health officer and the attorney general or deputy attorney general.

Since the secretary of the Board and all of the Board's records are located in Madison, it was considered more efficient that the designated representative of the Board be its secretary.

Chiros Get Investigator; Required to Have 2 Years College for License

Madison, Aug. 1.—Chiropractic activity was at an unusual low during the past legislative session. Two minor bills, 244, A. and 245, A., were passed; but a maneuver that might have legalized the practice of naturopathy was promptly squashed.

Bill 244, A. attempts to raise the educational standards required for chiropractic license. After July 1, 1960, all applicants for license must show preliminary education "substantially equivalent to the first two years of study in a regularly prescribed course for a bachelor of arts or a science degree accredited by the North Central Association of Colleges and Secondary Schools." At present, only high school education is required.

SMS OPPOSED

As presented, this bill was opposed by the State Medical Society because the wording apparently permitted chiropractors currently in school to obtain their pre-chiropractic education concurrently with their chiropractic training. This bill was also opposed by the Academy of Orthopathic Spineology, a chiropractic splinter group.

Bill 245, A. permits the State Board of Chiropractic to employ an investigator for the purpose of investigating chiropractors or the practice of chiropractic.

As originally prepared, the bill would have given the chiros power to investigate all phases of the Medical Practice Act, including physicians. This was eliminated by an amendment proposed by the Society.

643 CHIROS IN STATE

A maneuver, in the form of an amendment reported to have been prompted by naturopaths, would have given the proposed investigator power to check violations of chiropractic "as now practiced in Wisconsin . . ." This could have been a backdoor attempt to legalize naturopathy as many of these individuals are licensed as chiros but actually practice nothing more than naturopathy.

It might also have legalized the use of x-ray equipment, prescription of vitamins and other invasions of the field of medicine engaged in by some chiropractors. These aspects were revealed early in the session and eliminated by an amendment.

It is interesting to note that, in describing bill 245, A., the Wisconsin Chiropractic Association states that the bill would increase state revenues by $4,500. Since it proposed to increase annual chiropractic registration fees from $8 to $15, it would appear that there are 643 licensed chiropractors in Wisconsin at the present time.

SOCIETY REVIEW . . .

(Continued from page 387)

devotion to research and development of the Society's legislative program and the study of proposals put forth by various individuals and organizations.

The members of the committee responsible for this activity are: Drs. J. M. Sullivan, Milwaukee, chairman; J. P. Conway, Milwaukee; S. E. Gavin, Fond du Lac; J. K. Curtis, Madison; J. R. Schroder, Janesville; E. L. Bernhart, Milwaukee; and L. O. Simenstad, Osceola.

The following pages provide a summary of the more important legislation proposed, supported, or opposed by the Society.

Budget Cuts Sharply Curtail Future Public Health Plans

Madison, Aug. 1.—Public Health in Wisconsin suffered serious setbacks as a result of the adoption of the executive budget bill (73, A.). Passage of the bill has caused the State Board of Health to eliminate 10 or 12 salaried positions, and make substantial reductions in postgraduate scientific programs, health education material, and training programs for nurses.

A direct cutback of almost $70,000 has caused the State Board of Health to end its search for physicians to fill vacancies in three district health offices. These offices are located at Madison, Fond du Lac and Rhinelander.

In addition, the Board has had to drop vacant positions at the State Laboratory of Hygiene, two nutritionists, one engineer in the hospital construction program, one industrial hygiene engineer and two psychiatric social workers in the child guidance center program. Some of these had previously been filled but now have been cut from the budget entirely.

In the past, the State Board of Health has been able to finance postgraduate education programs for physicians in the fields of cancer, heart disease, maternal and child health, tuberculosis, and mental health; but its monies for these purposes have been sharply curtailed.

In addition, the budget for printing maternal and child health education literature has been slashed by $8,000. Funds for training public health nurses have been cut from previous highs of $8,000 to $12,000 to $2,000.

In part, the slash of personnel and program has resulted from a rewording of the budget bill to provide that federal funds be expended on a "line-item basis" as are state funds which are used to match those received from federal sources. Line items are salary, materials and supplies, and capital equipment. As a result of the new wording, funds which may be left over from one category are not transferable for use in another.

For some reason, this principle appears to have been applied only to State Board of Health funds as it is reported that other state agencies which receive federal support are not required to handle federal funds in the same manner.

Apparently in an effort to save the state an expenditure for activities in which federal funds are available, the budget bill placed restrictions on federal funds in excess of those provided in the state budget. The net effect of this change is that the spending of federal funds which exceed those provided by the state budget will result in a cut of an equal amount from the state budget.

The same is not true of funds in the area of categorical grants such as tuberculosis, venereal disease, mental health, maternal and child health, cancer and heart disease. However, the bulk of State Board of Health funds is in the "general health" category such as communicable disease and the like.

Intestinal Obstruction Due to Gallstone

Case Report

By C. F. ALTHAUS, M. D.
Hazel Green

MRS. D. B., a 58-year-old housewife, was admitted to the Hazel Green Hospital on October 21, 1954, for abdominal pain and emesis of three days' duration. Approximately six months earlier she had had an episode of severe right upper quadrant pain, radiating subscapularly, which lasted for several days. There were no indications of icterus at any time. Although the severe right upper quadrant pain subsided, the patient later began to have more and more a feeling of fullness, suffered from "gas," and had increasing anorexia and nausea. This developed into obstipation, emesis, and pain. At this time the practitioner treating her advised that she consult a physician since he felt that an intestinal obstruction had developed and she would require hospitalization. Her physician immediately hospitalized her.

On admission the patient was pallid and in a relative shock state. Her temperature was 97.6 F.; pulse 92, regular but thready; and blood pressure 100/70. The physical examination was essentially negative except for the abdomen, which was not distended or rigid, but tender all over, with generalized muscle resistance. It was relatively quiet on auscultation. Emesis material was positive for occult blood; the urine was negative microscopically and negative for albumin and bile. The white blood cell count was 25,100, with 96 per cent neutrophils, 2 per cent lymphocytes, and 2 per cent monocytes. A flat plate of the abdomen (Fig. 1) revealed a concentrically layered, round opacity 3 cm. in diameter at the distal end of the twelfth left rib. Barium study indicated that the opacity was not within the lumen of the large bowel.

Wangensteen suction was instituted and the patient prepared for laparotomy with the tentative diagnosis of (1) perforated gallbladder with secondary ileus, or (2) intestinal obstruction due to gallstone.

Under gas-oxygen-ether anesthesia a midline incision was made from the xiphoid to the umbilicus and the abdominal cavity explored. No free fluid was encountered. A firm, round mass about 3 cm. in diameter was found lodged in the jejunum. The bowel at this point was indurated, covered with a fibrinous exudate, and somewhat friable. The stone had apparently been lodged here for some time. Fortunately, it could be milked proximally without difficulty and was removed through a longitudinal incision which was closed transversely. The gallbladder was small, chronically thickened, filled with sand and stones, and plastered down to the duodenum at the ampulla by friable adhesions. On separating these, the point of perforation of the calculus from the ampulla into the duodenum was encountered and the defect

Fig. 1—Flat plate of abdomen.

closed with several silk interrupted mattress sutures. Cholecystectomy was then done and the common bile duct explored, but no additional stones were found.

After an uneventful course, the patient was discharged on the eighth postoperative day.

Summary

A case of intestinal obstruction caused by the perforation of a large calculus from the ampulla of the gallbladder into the duodenum, with arrest in the jejunum, has been presented.

Hazel Green Clinic.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1955, the March of Medicine began its tenth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 39 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WATK	Antigo	Saturday	8:45 a.m.
WHBY	Appleton	Saturday	8:30 a.m.
WATW	Ashland	Saturday	8:15 a.m.
WHSA	Brule	Saturday	1:15 p.m.
WHKW	Chilton	Saturday	1:15 p.m.
WCHF	Chippewa Falls	Saturday	9:00 a.m.
WHWC	Colfax	Saturday	1:15 p.m.
WHAD	Delafield	Saturday	1:15 p.m.
WEAU	Eau Claire	Saturday	11:45 a.m.
KFIZ	Fond du Lac	Saturday	4:00 p.m.
WBAY	Green Bay	Saturday	2:45 p.m.
WHHI	Highland	Saturday	1:15 p.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	10:45 a.m.
WLDY	Ladysmith	Saturday	9:30 a.m.
WHA	Madison	Saturday	1:15 p.m.
WIBA	Madison	Saturday	11:00 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Saturday	11:45 a.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	8:30 a.m.
WEKZ	Monroe	Friday	2:00 p m.
WPFP	Park Falls	Saturday	10:45 a.m.
WPLY	Plymouth	Saturday	8:30 a.m.
WIBU	Poynette	Thursday	2:45 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:15 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WRDB	Reedsburg	Tuesday	9:30 a m.
WOBT	Rhinelander	Saturday	9:05 a.m.
WHRM	Rib Mountain	Saturday	1:15 p.m.
WJMC	Rice Lake	Saturday	9:45 a.m.
WRCO	Richland Center	Wednesday	1:30 p.m.
WTCH	Shawano	Sunday	6:45 p m.
WLBL	Stevens Point	Saturday	1:15 p.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m
WTTN	Watertown	Tuesday	11:30 a.m.
WSAU	Wausau	Saturday	9:15 a.m.
WBKV	West Bend	Saturday	11:30 a.m.
WHLA	West Salem	Saturday	1:15 p.m.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Exposure to Virus Diseases in Early Pregnancy and Congenital Malformations[1]

There exists the rather current opinion that virus diseases such as German measles, measles, mumps, chicken pox, poliomyelitis, and influenza have a special liability for the production of congenital malformations. Dr. Carol Buck of London, Canada, reported a study made from the published vital data of the Bureau of Statistics, covering a period of seven years. The diseases especially studied were those mentioned above, and rates of mortality but not of morbidity were also studied. Plotted curves of incidence of congenital malformations related to incidence of viral diseases during the first trimester of pregnancy are strikingly devoid of any convincing evidence of any cause-and-effect relationship.

There appeared marked and somewhat periodic fluctuations in the rates of reported incidence of congenital malformations as appearing in the records of mortality, but these could not be correlated with the incidence of morbidity of virus diseases.

The apparent periodicity of the incidence of congenital abnormalities, if not accounted for by coincidence of morbidity from virus diseases, must then be due to some other factor or factors as yet undetermined. Perhaps the tragedy of morbidity is somewhat analogous or related etiologically to genetic abnormalities, *i.e.*, the genes.

When one ponders the marvelous complexity of man, as a biologic organism, one marvels that he has succeeded in surviving at all throughout the ages of his known existence. Earlier and less effective or less adaptive models of the human being did not—or is the writer wrong again?

Haemorrhagic Diathesis Attributed to "Warfarin" Poisoning[2]

"Warfarin" is a Dicumarol-like substance with a prolonged action; hence accumulation may occur on continued or frequently repeated exposure with absorption. In a rodenticide this property of a cumulative action very likely has its advantages. On the other hand, this same property may be a liability, as illustrated by an instance of a woman who had been preparing her own rat poison by mixing "Warfarin" with starch. Two possibilities of the route of her own absorption of the poison appeared; inhalation of the poisoned flour as a dust mixture, or the absorption of the poison through the skin. That the poisoning was that of the Dicumarol derivative was proved by the prompt correction of the hemorrhagic diathesis by use of vitamin K and also by the subsequent abstinence from further exposure to the mixture.

The gist of the matter is that human poisoning can occur through mishandling of this effective rodenticide.—A. L. TATUM, M. D.

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1. Buck, Carol: Exposure to virus diseases in early pregnancy and congenital malformations, Canad. M. A. J. 72:744–746 (May 15) 1955.
2. Green, Paul: Haemorrhagic diathesis attributed to "warfarin" poisoning, Canad. M. A. J. 72:769–770 (May 15) 1955.

EXHIBIT SPACE AVAILABLE AT WAGP MEETING

Scientific exhibits will be included as a part of the Wisconsin Academy of General Practice scientific assembly at the Milwaukee Auditorium, September 26 and 27.

A limited number of booths will be provided free of charge to physicians or organizations who have worth-while displays to present.

Anyone interested in obtaining a booth is encouraged to apply to:

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Lederle

Recent Advances in the Treatment of Retinal Detachment*

By JOHN B. HITZ, M. D.
Milwaukee

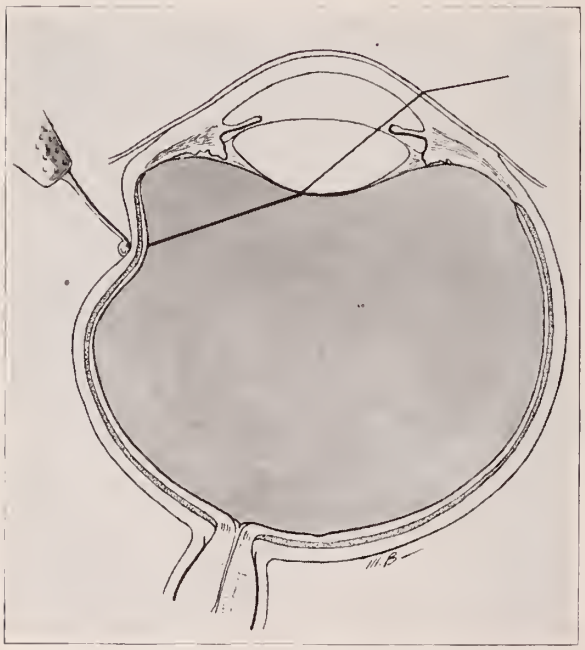

Fig. 1—Visualization of the fundus periphery by scleral depression.

TWO notable advances have been made in the therapy of retinal detachment in the last two decades, yet neither has developed the popularity and general acceptance it deserves. The binocular indirect ophthalmoscope is the first, and scleral resection is the second. The operation of scleral resection may consist either of the lamellar type or the complete procedure. The latter is used for the more difficult cases where large tears exist or where there is vitreous shrinkage, adhesions, and cases of so-called shortening of the retina.

By the early 1930's the treatment of retinal detachment had been well established. Gonin emphasized the importance of retinal tears, and reported the first successfully treated cases in 1925. Previously, cases had been cured by scleral resection but not by treating the tear directly. Weve and Larson introduced surface and micropuncture diathermy.

Weve's technic with modifications has become the standard procedure. It consists of accurate preoperative localization of the holes; localization during operation by ophthalmoscope and transillumination; confinement of surface diathermy or non-penetrating diathermy to areas of tears or degeneration; withdrawal of subretinal fluid by diathermy puncture plus suction; and verification at the end of the procedure that the tears have been sealed and the retina is in approximation to the choroid and, if not, the occasional use of air injection into the vitreous.

The introduction of the binocular indirect ophthalmoscope by Schepens in 1946 gives us an instrument which, because of its extremely powerful illumination, enables the surgeon to see through the previously impenetrable vitreous haze. Its low magnification and binocularity make it possible to see further into the periphery. Because it is mounted on a headband, both hands of the operator are free for such manipulations as scleral depression which permit visualization of the retina to its extreme peripheral attachment at the ora serrata. This latter technic is of especial value in the retinal separations found in aphakic patients because the majority of retinal lesions in these patients are anterior to the equator.

Figure 1 demonstrates how one can see the extreme periphery by scleral depression. Figure 2 shows the use of the indirect ophthalmoscope with the scleral depressor. Those who are trained in indirect opthalmoscopy will find that familiarity with the binocular ophthalmoscope is quickly acquired. Visualization of a scleral depressed area has been for me a slowly acquired skill, and I still do not feel proficient. It is extremely difficult to get the line of vision, the patient's pupil, the + 20 lens, and the area of depressed sclera all in one line. Depression can be quite gentle and is done through the skin of the lid

* Presented at the EENT Section Meeting, One Hundred and Thirteenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 6, 1954.

except in the 180° meridian, in which case a small amount of topical anesthesia may be necessary.

Scleral resection was first used by Müller in 1903, and in 1911 and 1912 he reported five cures in 15 cases. His original resections were as much as 10 mm. in width and 15 to 20 mm. long. This operation was not taken up with much enthusiasm; and it was revived and modified in 1931 by Lindner, who reserved it for cases with extremely high myopia. He considered it an eyeball-shortening procedure. Modifications of the complete scleral resection are in use successfully today by such men as Lindner, Hruby, Borley, Kronfeldt, and Pischel.

In 1949 the technic of lamellar scleral resection or scleral buckling came into existence. As far as I can determine, it was originated by C. Dee Shapland of England. These operations, both penetrating and lamellar, not only shorten the eyeball, but literally push a fold of choroid in toward the detached retina, which may be held away from the choroid by vitreous bands or a shrinkage of the retina itself. Figure 3 illustrates the technic of lamellar resection.

Two or three precautions are necessary. The width of the resection seems to enlarge so that an original 3 mm. resection may stretch to 4 mm., making the edges of the resection difficult to approximate.

The depth of the resection should be two-thirds the thickness of the sclera. This can be judged by the dark gray color which appears as the choroid is approached. The base of the resected area is gently coagulated with surface diathermy.

Too large a resection or too long in cases of flat detachment without much subretinal fluid may result in difficulty of closure. Fortunately, a safety valve is present in the use of anterior chamber paracentesis if the eyeball becomes too hard.

Another disadvantage is the use of non-absorbable sutures, silk in our cases, which increase the possibility of infection. Chromic cat gut, in the experience of most men, does not hold long enough.

It seems to us, inasmuch as lamellar resection is a safer operation from the standpoint of choroidal hemorrhage and vitreous loss, that the burden of proof of superiority rests with those who advocate penetrating scleral resection. Shapland, in the March, 1953, *British Journal of Ophthalmology*, reviewed

Fig. 2—Use of binocular indirect ophthalmoscope with scleral depressor.

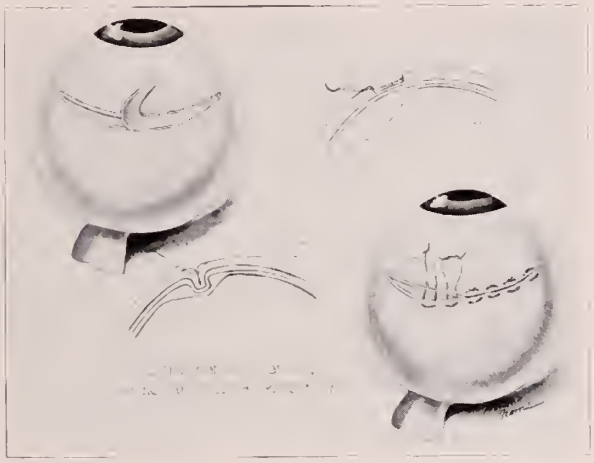

Fig. 3.

the cases reported up to 1951–1952 and feels that the results favor the lamellar procedure.

In the past two years my associates and I, with the assistance of the resident staff at Wood, have done 15 cases. Statistics in retinal detachment mean little because of the variability in the lesions, and certainly they mean nothing in such a small series; and, yet, without some figures it is difficult to evaluate any new procedure. Six cases were aphakic, with 3 successful and 3 failures. Nine cases were not aphakic. There were 6 primary operations and 3 secondary, with success in 5, failure in 3, and improvement but not complete reattachment in 1.

It is our conclusion that whenever there is considerable doubt as to the success of a classical diathermy procedure, the scleral resection (lamellar) should be employed as

a primary procedure. Secondary resections after extensive diathermy operations are extremely difficult and fraught with some danger of globe rupture.

Another procedure which has provoked considerable discussion recently is the prophylactic treatment of retinal breaks or cases of so-called subclinical detachment. I believe this problem will resolve itself to the differentiation of early subclinical flat detachments and retinal breaks without detachment. This can often be done by the careful mapping of peripheral fields and by the use of scleral depression. The former patients should definitely be operated upon. The latter can be watched; but in case of doubt, I feel they should be operated upon. These patients do not need prolonged postoperative bed rest, and surgical treatment consists of surface diathermy only over the area of retinal break. Three days' hospitalization is sufficient.

Two other advances related to the problem of retinal detachment should be mentioned.

There is increasing knowledge of the role of the vitreous, vitreous bands, and vitreous adhesions in the origin and prognosis of retinal detachment. The Hruby exhibit at the recent International Congress of Opthalmology demonstrated primarily the practical value of deep vitreous studies with the Hruby lens or contact lens in the diagnosis and prognosis of detachment. As an example, at times vitreous bands can be seen which would prevent retinal replacement by classical methods. At times the amount of subretinal and subvitreous fluid can be estimated, thus determining the amount of scleral resection. It behooves all of us interested in detachment surgery to learn more about biomicroscopy of the retina and deep vitreous.

The other interesting presentation at the congress relating to detachment was one by Dr. Meyer–Schwickerath of Bonn, Germany, on the use of a powerful beam of visible light (arc light) directly through the pupil onto the retina, causing retinal and choroidal coagulation. The possibility of the use of this method of treating posterior retinal tears and even small tumors is intriguing.

1324 West Wisconsin Avenue.

MINNESOTA ACADEMY OF GENERAL PRACTICE REFRESHER COURSE

The Minnesota Academy of General Practice will hold its fifth annual fall refresher course at the Radisson Hotel, Minneapolis, on Wednesday, October 19, starting at 8:30 a.m.

Seven hours of accredited postgraduate study will be provided in the form of concentrated instruction and lectures by 14 eminent medical authorities. The highlight of the noon luncheon will be a talk by H. E. Rynearson, M. D., Rochester, Minnesota. Some of the others on the full-day program will be Bert Seligman, M. D., Toledo; Gene Stollerman, M. D., University of Chicago; and George Logan, M. D., Rochester, Minnesota.

No charge will be made for registration. Purchase of a $5 luncheon ticket is the prerequisite to attendance.

A warm welcome to participate is extended to all doctors of medicine. Advance registrations are considered most advisable and should be made through:

James A. Blake, M. D.
15 Ninth Avenue South
Hopkins, Minnesota

OBSTETRICS AND GYNECOLOGY PROGRAM

The Wisconsin Society of Obstetrics and Gynecology cordially invites all members of the State Medical Society interested in obstetrics to meet at Sheboygan on October 15 for a full day's scientific program and discussion.

Details of the meeting will be announced by direct communication to members of the Wisconsin Society of Obstetrics and Gynecology and through the September issue of *The Wisconsin Medical Journal.*

Nonmembers desiring to participate in the meeting are asked to kindly signify their intention of attending by writing William V. Luetke, M. D., 1023 Regent Street, Madison, so that proper arrangements for the luncheon can be made.

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: E. W. Cauldwell, M. D.

REPORT OF A CASE*

A 49-year-old, white male entered the hospital on Nov. 8, 1954, complaining of episodes of dizziness, nausea, and a sensation of pressure in the lower abdomen.

His past history disclosed that he began to have right "migraine" headaches at the age of 4 years and continued to have them throughout his life, sometimes as often as once a week. As a child he had measles, mumps, whooping cough, and chicken pox. Twenty years before admission he was hospitalized with fever, cough, and pain in the chest. A diagnosis of lobar pneumonia was made, and the laboratory recovered type I pneumococcus. Antipneumococcic serum was administered. At that time the blood pressure was 128 systolic and 76 diastolic. The admission urine contained 3+ albumin with hyalin and granular casts; upon discharge, there was only a trace of albumin in the urine. Four years later, the patient experienced lumbar pain and passed blood in the urine. He was hospitalized elsewhere, and physical and laboratory findings were essentially negative. Three years before admission, he had an acute upper respiratory infection and was attended at home by his family physician, who recorded the blood pressure at 150 systolic and 100 diastolic. The ocular fundi were not remarkable. Eighteen months later, he passed a group insurance examination.

He was again seen by his physician nine months before admission because of pain in the left eye and sudden impairment of vision. Blood pressure at this time was 200 systolic and 130 diastolic. The urine was essentially negative. Raudixin was prescribed. The patient was considered to have a "chronic anxiety state," and worked at an intense, sustained pace in an effort to dispel his anxieties. His leisure time was preferably devoted to sleeping.

Retinoscopic examination by Dr. E. T. Jones disclosed that the fundus of the right eye had marked tortuosity of the vessels, widened light reflexes, and flame-shaped hemorrhages along arterioles, together with numerous fluffy areas of retinal edema and "cotton-wool exudate" scattered throughout the posterior pole. The macular region was relatively clear. The fundus of the left eye showed a similar picture with involvement of the macula by edema and hemorrhage. Optic papillae appeared normal. Vision was 20/25 in the right eye and 20/50 in the left. The patient was again seen two months later, at which time there was definite improvement in the fundoscopic picture. The fundus of the right eye contained only occasional flame-shaped hemorrhages; that of the left eye had occasional hemorrhages, and in place of the former fluffy areas of edema there were hard, shiny punctate markings.

During the following month, Apresoline was given in combination with Raudixin. The Apresoline was subsequently discontinued because of weakness, and hexamethonium was substituted. The latter drug was soon discontinued because of nausea and constipation.

Three months before admission, the eye symptoms recurred. At this time, there was a small hemorrhage in the macular region of the right fundus, and numerous hard, shiny exudates in the posterior polar regions with areas of fresh edema and hemorrhage in both fundi. There was no suggestion of papilledema in either eye. A urinalysis was negative.

Three weeks before admission, the patient entered the Wisconsin General Hospital, Madison, for evaluation and therapy. Physical examination revealed that the heart was enlarged and the apex was 10 cm. to the left of the midsternal line. The liver was enlarged. The blood pressure was 268 systolic and 158 diastolic. There was severe hypertensive retinopathy with hemorrhage, exudate, and choking of the disks, grade 4. The electrocardiogram disclosed left heart strain. A chest x-ray showed only moderate left ventricular enlargement. An intravenous pyelogram was normal. The laboratory examina-

* From Beloit Municipal Hospital, Beloit.

tions included a urinalysis with a specific gravity of 1.012, albumin 0.25 per cent, occasional white and red blood cells per high power field, and an occasional hyalin cast per low power field in the sediment. The Mosenthal concentration test produced a maximum specific gravity of 1.014. There was an output of 50 per cent of injected phenolsulfonphthalein at the end of two hours. The nonprotein nitrogen was 38 mg. per cent. A Sodium Amytal test produced what was considered to be an unsatisfactory fall of pressure to 194 systolic and 126 diastolic.

The family history was noteworthy. The man's grandfather had died of nephritis at 70, and his father had died of nephritis at 63. One aunt, one uncle, and one cousin also died of nephritis. An aunt and a cousin died of "hypertension." Two living sisters have hypertension, one with a systolic pressure consistently over 200. A six-year-old son is said to have migraine headaches.

Physical examination at the time of the current hospital admission revealed a man in no acute distress. The heart was enlarged to the left, and there was a slight systolic murmur at the apex. The lung fields were clear. The liver extended 3 fingerbreadths below the costal margin.

The temperature was 96.2 F., the pulse 76, and respirations 22. The blood pressure was 250 systolic and 150 diastolic. The patient weighed 122 pounds and was 67 inches in height.

Examination of the blood showed a red blood cell count of 4,330,000, hemoglobin of 11.5 Gm., and white blood cell count of 10,400, with 84 per cent neutrophils. The urine had a specific gravity of 1.016, albumin 2+, many red blood cells per high power field, and occasional hyalin casts in the sediment. The nonprotein nitrogen was 36 mg., and the uric acid was 6.2 mg. per 100 ml.

The patient was placed on a course of neostigmine, Serpasil, and Ansolysen (pentolinium tartrate). Response to therapy was considered unsatisfactory. Doses of Ansolysen large enough to have a significant effect on blood pressure produced an intolerable postural hypotension and even syncope. The patient was permitted to return home two weeks after admission for a holiday visit.

He was readmitted to the hospital six weeks later. Symptoms of dizziness, weakness, pain in the abdomen, headache, anorexia, and vomiting had become progressively worse. There was extensive loss of vision and a weight loss of 25 pounds. The admission blood pressure was 226 systolic and 128 diastolic.

The blood examination at this time showed a red blood cell count of 2,500,000, hemoglobin 7.5 Gm., and white blood cell count of 17,500, with 91 per cent neutrophils. The urine had a specific gravity of 1.014, 4+ albumin, and occasional granular casts. The nonprotein nitrogen was 207 mg. per 100 ml.

One week later, and again the following week, the patient voided a small amount of bloody urine. There were frequent involuntary liquid stools. On the twenty-first hospital day, he complained of severe pain throughout the upper abdomen; and on the following day, there was severe chest pain and pain in the left groin.

The patient was extremely restless, and morphine was given freely for the relief of pain. On the twenty-fourth day, the blood pressure was 126 systolic and 90 diastolic. The nonprotein nitrogen was 345 mg. per 100 ml., and creatinine 12.6 mg. per 100 ml. No urine was passed during the 72 hours preceding death. He expired quietly on the afternoon of the twenty-fifth hospital day.

Clinical Discussion

Dr. Richard A. Thayer: To begin with, the family history, with its repetition of nephritis and hypertension, is almost incredibly bad.

The patient's personality, with the anxiety traits and effort to work off worries, fits in with that so often seen in cases of labile benign hypertension.

Albuminuria and casts noted at the time of the pneumonia 20 years ago disappeared quickly with the subsidence of pulmonary infection, and many subsequent urinalyses were negative, so it seems unlikely that a chronic nephritis could have originated at that time.

Hematuria and lumbar pain four years later apparently could not be satisfactorily explained at that time, and the further course makes it seem improbable that any serious urinary disorder was present then.

In spite of all these suggestive factors, the patient appeared to be making a reasonably satisfactory adjustment and his hypertension continued to be labile.

Spells of blurred vision which occurred nine months before original admission were the first indication of impending complications. Whether vigorous antihypertensive treatment at this time would have changed the course of the disease is problematical. It is also questionable whether the patient would have been willing or able to accept such chronic invalidism. Perhaps a sympathectomy at this time might have given him a year or two more of life or made him more comfortable. This is mere speculation, however, as the patient did not consult a physician until his vision was impaired considerably, and the ravages of arteriolar disease were probably well under way.

When antihypertensive treatment was begun, he had probably entered into an early phase of malignant hypertension as witnessed by the exceedingly high diastolic pressure, marked retinopathy, and headaches. However, the kidneys were apparently still functioning normally.

The failure of various drugs to lower the blood pressure and relieve symptoms may have been due in part to the hypertensive personality traits which drove the patient to work whenever he was not actually sleeping, and to complain of side effects which made it difficult for him to work. However, in view of the eventual outcome, the disease was so severe and progressive at this time that any treatment was probably doomed to failure.

The heart remained well compensated up to the time of the patient's death. The chief problem seems to revolve about the apparently sudden onset of rapidly progressive kidney failure. From a negative urine three months before admission, to a 0.25 per cent albuminuria, and a nonprotein nitrogen of 38 mg. three weeks before admission, and a 2+ albuminuria and a 36 mg. nonprotein nitrogen upon admission, there was the abrupt change to a 4+ albuminuria and a precipitous rise of the nonprotein nitrogen to 207 mg. on readmission, which bespeaks of a rapidly progressive and suddenly fulminating renal lesion.

There was no acute infection or edema at the time the kidney failure began, so for these and other obvious reasons, an acute nephritis seems very unlikely.

Chronic nephritis, if present, was certainly so latent as to escape detection on numerous urine examinations. Nevertheless, a relatively quiescent chronic glomerulonephritis may manifest itself dramatically by suddenly entering a vascular phase and being first recognized as a malignant hypertension.

A normal intravenous pyelogram probably rules out urinary calculi, polycystic disease, and other severe obstructive lesions of the urinary tract; and absence of pyuria, episodes of fever, and back pain militate against pyelonephritis.

There was probably some degree of nephrosclerosis accompanying the benign hypertensive phase, but to attempt to decide whether it was the cause or the result of the hypertension in this case is clinically impossible.

The symptoms and signs expressed during the final hospital admission were those of rapidly progressive uremia, and the laboratory findings provided quantitative evidence.

Therefore, our diagnosis is (1) benign hypertension probably on the basis of arteriolar nephrosclerosis, which unaccountably showed transition into (2) malignant hypertension, accompanied by (3) severe hypertensive retinopathy, and (4) uremia.

Dr. William M. Fitzgerald: This case is especially interesting because of the unusually long clinical history of both normal and abnormal blood pressure recordings; continued prolonged apparent good health in spite of the suggestion of kidney disease 20 years and also 16 years before the final illness; episodic hypertension, which, of course, brings to my mind the possibility of pheochromocytoma; and, lastly, the obvious acceleration of the kidney disease within the three weeks prior to death.

Pheochromocytoma is not definitely ruled out in this case, although the absence of a palpable abdominal mass and the lack of distortion of the kidney shadow on the pyelogram might imply that it was not present. There was also no evidence of elevated temperature, excessive sweating, glycosuria, or postural hypotension to buttress this diagnosis. One must wonder what transpired to change so definitely a comparatively stable course of hypertension and compensated kidney function during those last three weeks of life, and to produce an irrevocable pattern of renal failure and uremia.

Undoubtedly, there were vascular changes in the kidneys which characterize the malignant phase of hypertension. What was the trigger mechanism? Is it possible to provoke

Fig. 1—Anterior surface of the right kidney showing cortical hemorrhages. Sagittal section of left kidney: corticomedullary hemorrhagic and ischemic necrosis, with perinephric hemorrhage and extravasation into retroperitoneal tissues.

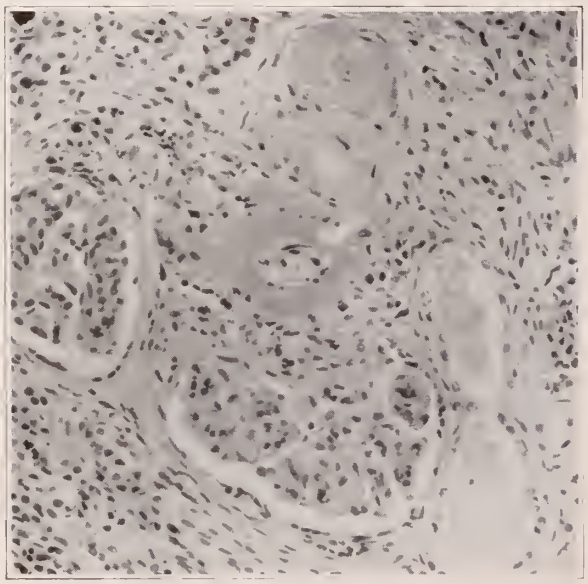

Fig. 2—Afferent glomerular and interlobular arteriolar necrosis (X 100).

or accelerate such changes through the use of potent adrenergic drugs such as Ansolysen, which was used in this case?

Medical therapy certainly proved to be entirely inadequate and was apparently ineffective from the outset. I think, all too often, that a lack of cooperation on the part of a patient of this personality type is as big a factor in defeating its effectiveness as any. In spite of lack of control of hypertension, he at no time exhibited evidence of vascular complications outside of the kidney; and one cannot but ask, as some clinicians are now doing, "How vigorously should hypertension be treated?"

Necropsy Findings

Dr. E. W. Cauldwell: At autopsy the impressive findings were largely restricted to the kidneys (Fig. 1). The right kidney weighed 120 Gm. The cortex was pale and of finely granular character, with punctate and diffuse hemorrhagic markings. The punctate hemorrhages were discernible throughout the cortex, and linear hemorrhages were found in the medulla. There were also hemorrhages in the mucosa of the renal pelvis. The left kidney was embedded in a mass of hemorrhagic perinephric fat, and blood had extended craniad beneath the corresponding adrenal gland and caudad to envelop the ureter at the level of the iliac vessels. The entire lateral half of the renal parenchyma was replaced by massive hemorrhage, which was fairly well demarcated from adjacent, soft, yellow-tan parenchyma. Discrete and confluent hemorrhage occurred in the latter tissue. There were also hemorrhages into the pelvic mucosa. The kidney was supplied by two renal arteries, both of which were moderately involved by arteriosclerosis. The lumen of the craniad vessel was partially occluded by blood clot at the level of entrance into the hilum. Occluded interlobar branches of both arteries could be discerned grossly. The ureters were bifid for a distance of 5 cm. The urinary bladder was not remarkable except for a submucosal hemorrhage at the left lateral junction of trigone and prostatic urethra. In addition, there were superficial erosions of the ascending colon, left ventricular myocardial hypertrophy, moderately severe coronary arteriosclerosis, and fibrous pleural adhesions. The heart weighed 425 Gm.

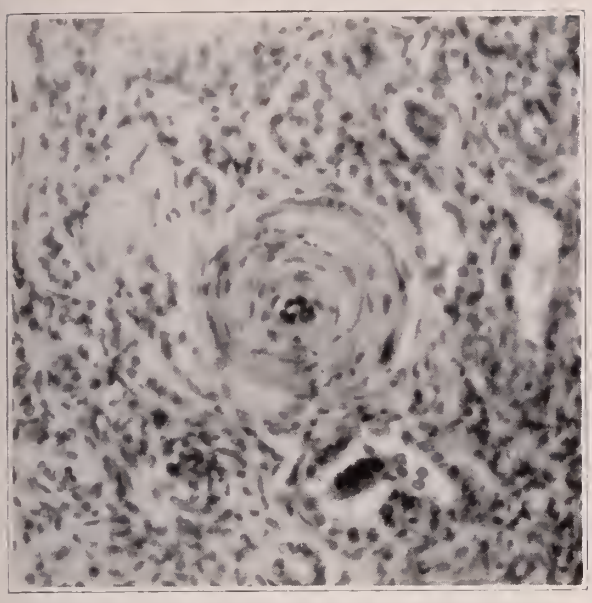

Fig. 3—Intimal fibrous hyperplasia in interlobular arteriole (X 100).

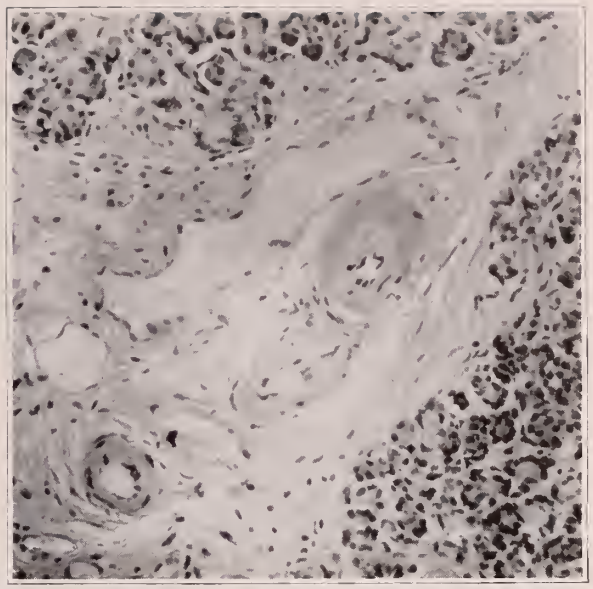

Fig. 4—Severe intimal hyalin change in pancreatic arterioles (X 100).

Microscopic study added evidence for an accelerated (or malignant) vascular phase of hypertension in the form of arteriolar necrosis affecting arterioles of interlobular and afferent glomerular type (Fig. 2). There was a severe degree of intimal hyalin change and intimal fibrous hyperplasia of the interlobular vessels (Fig. 3). In the left kidney there was widespread necrotizing arteriolitis and arteritis, thromboses of portions of interlobar and arcuate arteries, and thromboses or occlusive hyperplastic fibrosis of the interlobular arterioles. There was extensive coagulative necrosis of the proximal renal parenchyma and hemorrhagic necrosis of the distal corticomedullary architecture. In the noninfarcted areas of the left kidney, afferent glomerular arteriolar necrosis and hyalin thrombi in glomerular loops were seen. There were no adhesions between tufts and glomerular capsules, and no crescent formation. There was, in addition, severe hyalin thickening of the intima of arterioles of the myocardium, liver, spleen, pancreas, and adrenal capsule (Fig. 4). There were areas of focal myocardial fibrosis related to the coronary artery disease. The mucosa of the ascending colon was edematous and included numerous small acute ulcers infiltrated by polymorphonuclear leukocytes. This was considered to represent an acute uremic colitis.

In summary, this man entered the hospital with a relatively short history of severe hypertension, and with a marked degree of hypertensive retinopathy, but apparently possessing a fair degree of renal competence. For some unknown reason, a fulminant malignant nephrosclerosis with accompanying uremia developed and caused death within three and one-half weeks of the final admission. The presence of an area of massive hemorrhagic necrosis, pericapsular hemorrhage, and ischemic infarction of the corticomedullary parenchyma was a very unusual finding in a case of malignant hypertension. These pathologic processes were apparently related to the involvement of portions of the interlobar and arcuate arteries by the necrotizing lesion, with resulting thromboses. The pattern of the right kidney was basically one of benign arteriolonephrosclerosis, with superimposed arteriolar necrosis of malignant nephrosclerosis.

The areas of infarction in the left kidney were consistent with lesions of a relatively few days' duration, and might be timed with the sudden onset of abdominal pain four days before death. This picture would also correlate with the extreme degree of restlessness and persistent pain in spite of heavy morphine sedation, and with the anuria during the last three days of life.

Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

Editor—DOROTHY W. BETLACH, M. D., Janesville, Wisconsin

Explosion Hazards in Anesthetizing Areas

Fire and explosions in anesthetizing areas are tragedies which happen when least expected. Eighty to one hundred explosions are reported for an estimated 10 million anesthesias yearly in this country.[1] Fortunately, mortality rate is but one in 150,000 surgical cases.[2] The general public does not understand thoroughly the hazards of combustible agents, however; and often harmful publicity and legal action result. The automobile kills twice this number in a single 24-hour period without creating such public interest. Since definite hazards are present in places where flammable anesthetic agents are used, definite precautions must be taken to avoid or further minimize catastrophies.

George J. Thomas, M. D.,* expert in the study of anesthetic explosions and their prevention in conjunction with research conducted by the Explosives Division of the United States Bureau of Mines and the Mellon Institute of Research in Pittsburgh, recently demonstrated explosion hazards and presented sound recommendations for adoption by hospitals and all personnel concerned with the use of flammable anesthetic agents. Excerpts of his discussion are presented by the Wisconsin Anesthesia Study Commission.

Three factors essential for the development of an anesthetic explosion are:

1. Combustible gases or vapors
2. Oxygen supply
3. Ignition source.

Combustible gases used in ordinary anesthesia practice are cyclopropane, diethyl ether, divinyl ether, and ethylene. Nitrous oxide combined with ether becomes a combustible mixture. Chloroform may contain alcohol which is flammable. Likewise, trichlorethylene in concentrations of 10.3 per cent is flammable. Some hospital administrators believe they can prevent explosion hazards by eliminating the use of cyclopropane and ethylene. This is not true. There is *"no safety in ether."* Explosions of ether occur with as little as 4 minims of ether mixed with air under the proper static conditions. Others have suggested the exclusive use of noncombustible agents such as Pentothal,[R] curare, and regional agents. Frequently a patient's condition is so precarious that the use of these agents would be detrimental to his well-being. Combustible agents are valuable adjuncts which cannot be eliminated.

Oxygen is necessary to all ordinary combustion. In anesthesia a constant oxygen supply to the patient is absolutely essential for life.

Flammable mixtures require an ignition source for an explosion to occur. Ignition sources may be small flames, incandescent surfaces, and electric sparks.

Factors 1 and 2 are indispensable to practical anesthesia. However, the third factor, the ignition source, is not essential and should be controlled or eliminated.

Open flames, as from alcohol lamps, Bunsen burners, matches, and lighted cigarettes, should be prohibited in operating rooms and other areas where anesthetics are administered or may be present. Corridors and lounge rooms adjacent to anesthetizing areas must be included in this restriction.

Cautery and diathermy must not be used near the head, neck, chest, or respiratory tract of a patient while a flammable anesthetic agent is being administered. It is estimated that a flammable gas escaping from a machine or respiratory system is explosive within a distance of 2 feet from the gas leak.

Explosions of ether have occurred as a result of the formation of peroxides on exposure to sunlight. Ether should always be stored in the original containers or dark glass bottles. Any ether remaining in the

* Director, Department of Anesthesiology, University of Pittsburgh School of Medicine, St. Francis and Medical Center hospitals, Pittsburgh, Pennsylvania.

anesthesia machine should be removed and properly stored at the end of the day's work.

Electrical equipment such as suction machines, switches, extension cords, outlets, lamps including endoscopes, and x-ray apparatus should be inspected frequently to detect faulty operation, broken switches and plugs, frayed cords, and open sparks. Unless the equipment is explosion-proof, it should not be used where concentration of flammable anesthetic gases may be present. Receptacles and plugs should not be placed in or near the floor where heavy anesthetic gases are apt to pass over them. Electrical apparatus should not be connected or turned on during an operation in the presence of escaping combustible gases. The anesthetist always should be asked before any such connection is made.

In new building construction the electric wiring should conform with the latest approved regulations of the National Fire Protection Association, and the National Electrical Code.

Eighty per cent of fire and explosions are due to electrostatic charges. Static electricity is electricity at rest. This type results from friction and is deposited upon insulated physical objects.

Friction between dissimilar, nonconductive materials will produce static charges. Some examples of this are the shuffling of feet across a rug on a dry day, running a comb through the hair, rubbing a glass rod with silk or woolen cloth, or separating blankets or unfolding them. Considerable voltage also may be generated by simple routine procedures such as the placing of drapes on a patient or sliding forward on a cushioned stool. Static charges can be generated between silk, nylon, or rayon and other nonconductive materials. Charges also can accumulate on articles that are near electrically charged objects.

Most materials permit electricity to pass through them, but some materials are such poor conductors that they are considered insulators acting as a barrier to the flow of electricity and thereby serving as a generator of electrostatic discharge. Metals and carbon are good conductors, whereas acids, salt solutions, plants, and animals are partial conductors. Various oils, dry wood, silk, rubber, plastics, glass, and dry air are considered insulators.

It is almost impossible to prevent the development of electrostatic charges in operating rooms. There is so much activity that frequently friction is produced by contact with nonconductive materials that are present in the room, and charges are thus generated. Careful, deliberate movements by the operating team can help prevent the build-up of high voltages.

The only means to prevent the accumulation of static charges is to provide paths by which the electrostatic charges flow away as fast as they are generated. All movable objects present in a room where flammable anesthetic agents are administered should have proper electrical contact with an efficient conductive floor.

Grounding chains are useful for removing static electricity from operating room equipment only under the following conditions:

1. The floors must be definitely conductive or have metal dividing strips closely spaced.
2. The chains should make long-line contact with the floor, at least a 4 to 8 inch drag, if the floor is conductive, or with at least two metal strips if it is not. Chains that are so short as to provide only one or a few links in contact with the floor cannot be relied upon to remove static. Long chains on tables, stools, carriages, gas machines, etc., will not be in the way if they are placed diagonally underneath the equipment with *metal* screw attachment.
3. To insure greatest safety, dirt, wax, grease, soap, oxide films, or other foreign substances that may accumulate between the links and cause high resistance should be removed frequently with a stiff brush and a greaseless detergent.
4. Chains having open links are to be preferred to those of the ball or beaded type which have conductive parts that are inaccessible for cleaning. They should be of material that will not rust or give off abrasive sparks when dragged over concrete or other hard surfaces.

In the event the floor has high resistance, a satisfactory solution to the problem has been found in the use of one moistened and two wet towels. Turkish towels maintain moisture for a long period of time. The first towel is moistened and folded lengthwise; one end is placed under the patient's shoulder (against the bare skin), and the other end is tucked between the mattress and the top of the operating table. A second towel is wet and laid from the base of the table (above the caster) to the floor toward the anesthetist's foot. A third towel is also wet

and is stretched from the foot of the gas machine to the floor. The anesthetist's foot and the stool touch one or both of the towels. Moistened and wet towels employed in such a manner will provide excellent conduction and grounding even though a standard test may indicate high floor resistance. Conduction of electricity to ground through a floor is accomplished through many paths of high resistance. When a contact to the floor is made with a chair, plate, or a chain, only a few of the available paths to the ground are used. When contact is made through a wet towel, cloth, or pool of water placed on a floor, thousands of such paths are made available and the neutralization of charges is easily made.

Floors made of rubber, linoleum, porcelain tile, or marble are poor electrical conductors. Neutralization of charges through such floors is a slow procedure, and a dangerous spark may occur before neutralization is complete. Floors made of magnesium oxychloride, and containing finely divided metallic copper, have suitable electrical resistance and are satisfactory. Other types of satisfactory conductive floors include conductive vitreous ceramic floor on a 1-inch conductive underbed, conductive vinyl plastic tile, and carbon black terrazzo floor which is properly installed and maintained. Oil-base or strong alkaline detergents will raise the resistance of conductive floors and should not be used for cleaning. Corridors adjacent to operating areas should be conductive, too. In planning the installation of conductive floors, consideration must be given not only to conductivity but to cost, durability, and appearance.

Good ventilation of the areas helps prevent pooling and concentration of anesthetic vapors. Humidity should be controlled at 50 per cent or higher throughout the year. High humidity is not an absolute guarantee that static explosions will be eliminated. Several explosions have been reported with relative humidity at 65 per cent and, recently, an explosion was initiated by a static spark when the relative humidity was 76 per cent. There is no substitute for good conductive floors and connections.

Each gas machine should be equipped with conductive rubber breathing tubes, mask, and bag. All connectors should be metal or of some other conducting material. Plastic connectors are nonconductive. Ordinary, high-resistance rubber casters are present on most gas machines. Conductive rubber casters are available, but these are effective only while they are clean and new. It is possible to make a stainless steel caster that will be efficient and quiet and remain conductive indefinitely.

Moving anesthetic appliances is always dangerous; and extreme caution should be exercised, especially when they are moved across nonconductive floors. Altering the connection, or changing connections, during the course of anesthesia is hazardous and should be done with extreme care. It is much safer to move the patient with the gas machine completely disconnected and, after the proper grounding has been accomplished, to reconnect the gas machine and carry on from there.

Mattresses, pads, and pillows should be covered with conductive rubber. All stretcher carriers should be equipped with conductive rubber, especially where nonconductive floors are still used. Operating tables, anesthesia stands, stools, and instrument tables should be equipped with a conductive material at the points where they make contact with the floor. Stools should be left bare or covered with conductive materials. Wool blankets, plastic sheets, sponge rubber cushions, and most of the usual synthetic fabric materials should not be used in the operating room. Cotton blankets are satisfactory; but if they are kept in a warming compartment, some means should be provided to keep them from losing moisture.

Any individual within an operating room may cause an explosion of the anesthetic mixture. Cotton uniforms are essential because they retain a satisfactory conductivity at fairly low humidities and because they do not produce or acquire electrical charge by frictional contact with other much-used cotton articles. Conductive shoes should be worn by all operating room and obstetrical personnel. Personnel wearing ordinary rubber or synthetic-soled shoes may be static carriers regardless of the type of floors in use. *No one*, including visitors and observers, should be permitted in anesthetizing areas unless properly clothed in cotton outergarments and wearing conductive shoes. Street clothing should be changed. There is evidence that personnel wearing properly covered undergarments of silk or synthetic materials do not acquire substantial static charge poten-

tial. However, woolen socks will inhibit the effectiveness of conductive shoes. Every hospital should have shoe-measuring equipment to determine conductivity.

Visitors should not be allowed to make contact or come close enough for a spark gap with any object of the operating setup. Nothing should be placed inadvertently on the anesthetic apparatus nor should it be touched without the anesthetist's approval. If one must be near the anesthetist, contact should first be made with him to establish isopotential state.

Anesthetists can do much to prevent static charges. Contact with the patient and the anesthetic apparatus should be made before induction and constant contact with the patient maintained during the anesthetic administration. In the assembly and adjustment of any part of the apparatus and its connection with the patient, the anesthetist should hold both parts in his own hands before making or breaking contact. Movements should be deliberate.

Certain precautions must be exercised in the use of oxygen equipment. Do not permit oil, grease, or flammable liquids to come in contact with oxygen cylinders, valves, regulators, gauges, or fittings. Regulators, fittings, and other connections should not be lubricated with oil or any other combustible substance. Particles of dust and dirt should be cleared from the outlet of each cylinder by slightly opening and closing the valve before applying any fitting to the cylinder. Oxygen should not be permitted to enter the regulator suddenly. The valve must be opened slowly, and the face of the regulator gauge should be pointed away from the operator and other personnel. Do not attempt to use regulators that are in need of repair or cylinders having valves that do not operate properly.

Regardless of precautions, an isoelectric state is impossible for everything in the operating room. It is therefore the duty of the surgeons, anesthesiologists, nurses, and other operating and delivery room personnel to be thoroughly instructed in all of the causes of anesthetic fires and explosions. This duty should be impressed on each member constantly, and a method should be devised to insure complete adherence to all recommended precautions.

Manufacturers, architects, and builders concerned with hospital construction should be thoroughly familiar with all the hazards and should supply materials and construction that will conform with the necessary precautions.

Always be on the alert against that silent, unseen hazard that is least understood and most neglected—"static or frictional electricity." A spark that can not be seen or felt can prove disastrous.

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BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the last half of 1955 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who are referred by their family physician for orthopedic diagnosis and consultation. Reports of the examination are then sent to the referring physician following the clinic. Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons desiring clinic services. Medical referral forms are made up for the individual clinics, so requests should specify number of forms wanted and for which clinic they are wanted.

Families who return the signed referral form will be notified of the day and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

Marinette	September 7
Kenosha	September 14, 15
Superior	September 22, 23
Green Bay	September 29, 30
Racine	October 5, 6
Eau Claire	October 10, 11
Sheboygan	October 19, 20
La Crosse	October 25, 26, 27, 28
Rhinelander	November 2, 3
Fond du Lac	November 18
Appleton	December 1, 2
Chippewa Falls	December 8, 9

Inquiries concerning these clinics may be addressed to The Bureau for Handicapped Children, 146 North, State Capitol, Madison 2, Wisconsin.

. . . . THE PRESIDENT'S PAGE . . . .

We Need To Think Ahead

THE state legislature has recessed until October, and there is much to be praised in the record of the session just concluded. The passage of the State Medical Society's recommendations on the commitment of the mentally diseased is worthy of a "gold star" for achievement. It presages a new day for the long misunderstood and unjustly stigmatized epileptic. At the same time, the changes put a new light on the mentally disturbed, especially in the early, delicate stages of commitment when proper handling can mean so much to the afflicted and his family. One's conscience is stirred that these humane procedures have been so long in coming.

A new children's code may be even more significant in its implications for those Wisconsin youth who need special help in finding a secure place in society. Little noticed, but highly important, was the legislature's firm disposition of quack and cultist proposals. In an age when notoriety too often serves as the standard for reliability, the legislator who consistently withstands the blandishments of cultism is truly worth noting.

Despite this fine record, however, the first session of the 1955 legislature ended with several major problems unsolved. The medical examiner system, direly needed for proper administration of justice and protection of the public, is hanging on a financial question mark. Fortunately, the legislature appears to have accepted the principle. Still under study is a new criminal code that may be of material assistance to law enforcement officers in controlling the criminal abortionist.

Public health was shaken by the drastic cuts in appropriations which, among other things, virtually scuttle hope for district public health officers to serve the areas around Madison, Fond du Lac, and Rhinelander.

In spite of growing public recognition of the basic health services and assurances that are provided by sanitarians, nutritionists, and engineers, the thumbs-down attitude on the State Board of Health budget is something to note with anxiety. We don't blame the legislature for trying to economize, but there is another side to this situation which demands ability on the part of the legislature to think ahead and take imaginative action. Disease prevention is certainly more economical than the treatment of disease and the handling of its many family and community by-products. Disease control, once won, is maintained only by concerted vigilance. The advances in public health which have won Wisconsin an enviable reputation as "a good state to be born in" should never be allowed to halt or go into reverse.

Not only the legislature needs to think ahead on these matters. All thoughtful citizens should be thinking ahead. And, in that process, all physicians who have an intelligent concern for the health of Wisconsin people should be taking their part.

Ervin L. Bernhart M. D.

PRO-BANTHINE FOR ANTICHOLINERGIC ACTION

Abnormal Motility as the Cause of Ulcer Pain

Until recently the general opinion was held that ulcer pain was primarily caused by the presence of hydrochloric acid on the surface of the ulcer.

Present investigations[1,2] on the relationship of acidity and muscular activity to ulcer pain have led to the following concept of its etiologic factor:

"... abnormal motility[2] is the fundamental mechanism through which ulcer pain is produced. For the production and perception of ulcer pain there must be, one, a stimulus, HCl or others less well understood; two, an intact motor nerve supply to the stomach and duodenum; three, altered gastro-duodenal motility; and four, an intact sensory pathway to the cerebral cortex."

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THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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Volume 54 AUGUST 1955 Number 8

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Freedom in Research*

The public and the medical profession have been treated to a frenzy unlike any of similar nature in the history of medicine,—the debacle of the vaccine for poliomyelitis. This statement has no reference to Salk's basic research or to the statistical evaluation by competent medical scientists.

These editorial comments are made not from any detailed knowledge of events which led to the announcement of the results of the vaccine's application, nor of the machinations of lawmakers or public officials after the results were publicized. Rather they represent philosophical thoughts relative to basic research, its application to practical medicine, and freedom of the investigator to proclaim the results of his research when and where he pleases.

Research basically represents the search for truth. Truths are usually arrived at only by hard work and at the expense of much time,—time spent in checking and rechecking until the investigator can feel certain enough to stand before his peers and announce the results of his work. When the research involves biologic phenomena the investigation demands even more time than when dealing with mathematical, physical, chemical, or even with *in vitro* biological questions. Nature does not readily give up her secrets, and denies them through vagaries that try the patience of the investigator who hopes to solve the processes of life. It is these vagaries and the unanticipated actions or reactions that require, at times, seemingly endless checking and rechecking.

Jenner, Pasteur, Behring, Ehrlich, Banting and Best, Minot and Murphy, Kendall and Hench presented their findings to the sober criticism of their brothers in science. Theirs was freedom of research and expression even though the practical application touched the health and happiness of millions of sick people in the aggregate.

In contrast to this stands the announcement of the results of vaccination for poliomyelitis, a televised program, covered by newsmen and with an audience of prominent laymen. Unquestionably this setting was much to the distaste of the principal participants. They would without doubt have preferred to report their findings some days later at the scientific forum of the American Society of Clinical Investigation.

Why have we seen this first deviation from the usual in the reporting of scientific work? Your editor knows no facts but speculates on what he sees between the lines. May this be the first major example of the effect when research and its disposition is no longer the property of the investigator, to be publicized when the time is proper? May it mean that the research is the property of those who sup-

** Reprint of editorial appearing in the Southern Medical Journal, Journal of the Southern Medical Association, July 1955.*

ply the funds? Here lie dangers to medical research,—that the organizer who raises funds or the political body which disburses tax funds must justify their existence by "producing," and as in the auto factory hope to see research come off the line like cars. Be it said to the everlasting credit of those who disbursed the funds of the tycoons and philanthropists, they gave science carte blanche and meddled not in what was unknown to them.

These words are not to be interpreted as reactionary expressions, but rather as speculations for the good of humanity. The recent episode might serve as a lesson never to be repeated. Never again should laymen either through ulterior motives or from misguided judgment be permitted to build up the hopes of an emotional public to a hysterical frenzy, whose frustrations then cause lawmakers to make unseemly political capital of the situation,—witness the multitude of bills concerning the vaccine entering the hopper in Congress.

Matters such as the vaccine for poliomyelitis must be left in the hands of the investigator and the professional personnel working with him. He only will know when results are ready for publication. And, if it seems better to wait yet another year or two, or more, for double checking, so it should be. For the researcher must be as objective in attaining the end result, though some persons may die because of delay, as the surgeon entering upon an operation entailing a 20 per cent operative mortality. In the same way the investigator knows the hazards and decrees the safeguards. If these were lacking in the present episode, the responsibility lies at the door of whatever influences led to the fanfare and possible prematurity in the publication of results.

The layman must learn that the medical investigator should be free of pressure; only in this way will he make his greatest contributions to the health and welfare of the people.—EDITOR.

Dean Bowers

All Wisconsin medicine welcomes Dr. John Z. Bowers to his new position as dean of the University of Wisconsin Medical School. He brings to the school a tremendously significant background in this age of atomic medicine. His coming may well mean a new era for medicine at the University of Wisconsin.

Doctor Bowers is a native of Maryland and received his Doctor of Medicine degree from the University of Maryland School of Medicine in 1938.

He came to Wisconsin from the University of Utah, where he served as dean. He has been the medical consultant to the director of the Atomic Energy Commission, Division of Biology and Medicine, in which he once served as deputy director. At one time, also, he served as chief of the medical branch of the division.

As an author and lecturer, he is well known in scientific circles for his reports on studies of irradiation injury and for outstanding contributions to the use of television in medical education. Doctor Bowers recently told the Council of the State Medical Society of some of the serious problems facing medical schools today. He emphasized the need for the cooperation and assistance of the Medical Society in medical education because "only by mutual effort can we provide the best kind of medical care for the people of this state." Wisconsin has long been noted for its circuit postgraduate teaching programs, and Doctor Bowers urged their continuation as a vital part of the teaching of medicine. Equally important, he expressed the hope that the medical school and the Medical Society can maintain the closest kind of relationship "so that the medical school and its students can appreciate current problems of medical practice."

These are welcome words, Doctor Bowers, and the medical profession extends its congratulations and best wishes in your new position.

REMEMBER WHEN!

Wisconsin medical students need your help. Your contribution to the Student Loan Fund of the State Medical Society is needed now. Contributions are tax deductible on both federal and state returns.

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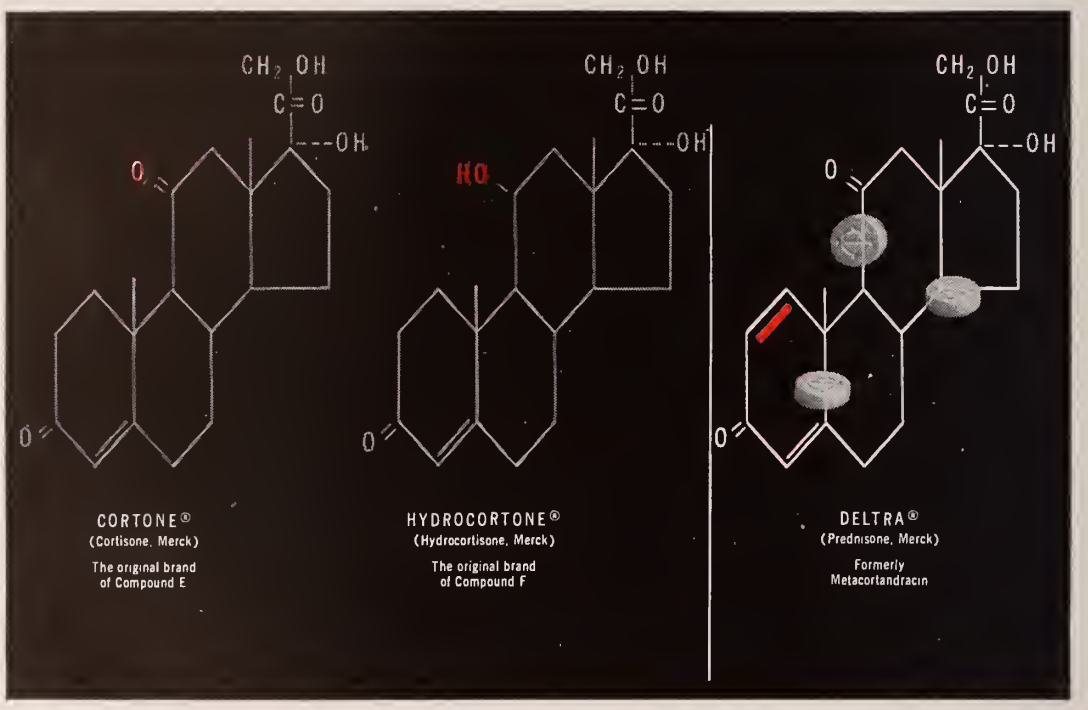

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EAU CLAIRE, WEDNESDAY, SEPTEMBER 14, 1955

AFTERNOON PROGRAM—Sacred Heart Hospital
(Guild Hall)

DINNER AND SYMPOSIUM—Eau Claire Hotel

Program

MODERATOR: Ralph C. Frank, M. D.

Eau Claire

1:30 **REGISTRATION**

2:00–5:15 **CANCER OF THE SKIN:** Sture A. M. Johnson, M. D., Professor of Dermatology and Syphilology, University of Wisconsin Medical School, Madison

THE RADIOLOGIC DIAGNOSIS OF LUNG CANCER: Lester W. Paul, M. D., Professor of Radiology, University of Wisconsin Medical School, Madison

CANCER OF THE THORACIC CAVITY: Joseph W. Gale, M. D., Professor of Surgery, University of Wisconsin Medical School, Madison

ORAL CANCER: Daniel M. Laskin, D. D. S., Assistant Professor of Oral Surgery, University of Illinois College of Dentistry

6:30 **DINNER AND SYMPOSIUM:** Ralph C. Frank, M. D., Eau Claire, Presiding

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Reservations: The only charge is that for dinner ($3.00 including gratuities). All other costs are covered by the Wisconsin Division of the American Cancer Society. Those who have not made their reservations are urged to do so. Send a check (made payable to the American Cancer Society, Wisconsin Division) and mail to STATE MEDICAL SOCIETY OF WISCONSIN, BOX 1109, MADISON.

Society Proceedings

Dane

The regular meeting of the Dane County Medical Society was held on June 14 at the Madison Club, Madison. At that time a report was made to the membership on the activities of the Public Relations Committee.

Pierce–St. Croix

Dr. Edward Juers, a specialist in orthopedic surgery, Red Wing, Minnesota, presented a discussion on treatment for fractured hips at the monthly meeting of the Pierce–St. Croix County Medical Society on June 20. The meeting was held at the home of *Dr. A. R. Aanes,* Ellsworth.

Polk

Polk County society and auxiliary members were guests of *Dr.* and Mrs. *Lorne Campbell* of Clear Lake at the June 16 dinner meeting of the society, which was held at Indianhead Lodge at Balsam Lake. *Dr. Walter O. Paulson* of the Midelfart Clinic, Eau Claire, was the speaker and discussed maternal mortality statistics. Fifteen members were present at the meeting.

Richland

Members of the Richland County Medical Society met at the Richland Hospital library, Richland Center, on June 16.

Dr. Benjamin Glover, Madison, addressed the 12 members present on the subject, "Hysteria."

Trempealeau–Jackson–Buffalo

Members of the Trempealeau–Jackson–Buffalo County Medical Society held their regular meeting at the Club Midway near Independence on June 28. A film, "Management of Streptococcal Infection and Its Complications," was shown.

Waupaca

The Waupaca County Medical Society held a dinner meeting for members and their wives at the Elwood Hotel, New London, on July 14.

Guest speaker at the meeting was *Dr. E. L. Bernhart,* president of the State Medical Society. He discussed the use of the Salk vaccine and the problems created by the introduction of this new vaccine.

Second Councilor District

On June 22 members of the Second Councilor District, composed of Racine, Kenosha, and Walworth

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counties, met at the Big Foot Country Club at Fontana, Wisconsin.

In the morning an educational program was held. Speakers were *Dr. Max Fox, Dr. Richard H. Segnitz,* and *Dr. Burton Waisbren,* all of Milwaukee, and Mr. C. H. Crownhart, secretary of the State Medical Society. A luncheon was held at the country club at noon, followed by a golf tournament during the afternoon, and dinner and dancing for members and their wives in the evening.

Fifth Councilor District

Dr. Nathan Smith Davis of Evanston, Illinois, was the featured speaker at the Fifth Councilor District meeting held on June 23 at the Hotel Manitowoc, Manitowoc. His subject was "What's New in Medicine."

Dr. Nelson Bonner, Manitowoc, presided over the meeting, which also featured talks by faculty members of Northwestern University School of Medicine. Professor Earl O. Latimer spoke on "What's New in Surgery," and Professor Ronald Greene spoke on "What's New in Obstetrics and Gynecology." A question-and-answer period followed.

Members of the councilor district and their wives attended a banquet in the evening. Officers of the State Society were present as honor guests.

Wisconsin Society of Public Health Physicians (Correction)

In the report on the meeting of the Wisconsin Society of Public Health Physicians, page 26 in the June issue of the Journal, the last paragraph reading, "The society voted to hold its fall meeting at the Eagle Waters Resort at Eagle River, Wisconsin, on September 10 and 11," should have been omitted.

Wisconsin Heart Association

New officers were elected by the Wisconsin Heart Association at its annual meeting, held at Brooks Memorial Union, Marquette University, Milwaukee, on June 4. Attorney Charles S. Quarles of Whitefish Bay succeeded *Dr. Howard L. Correll,* Milwaukee, as president. *Dr. John K. Curtis,* Madison, was named president-elect; and Gardner L. Friedlander of Whitefish Bay was elected secretary–treasurer.

The guest speaker for the occasion was Dr. Herrman Blumgart, professor of medicine at Harvard University Medical School, Boston. He discussed the use of radioactive iodine in the treatment of heart disease.

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News Items and Personals

Doctor Busse Governor of Chest Group

Dr. Alfred A. Busse, Jefferson, was re-elected governor of the American College of Chest Physicians, for Wisconsin, when the College held its annual meeting at the Ambassador Hotel, Atlantic City, New Jersey, June 1–5. *Dr. Andrew L. Banyai*, Milwaukee, was awarded the gold medal of the College for meritorious achievement in the specialty of diseases of the chest.

Doctor Elliot, Fox Lake, Honored

Members of the Dodge County Medical Society gathered at the Waupun Country Club, Waupun, on June 11 to honor *Dr. E. S. Elliott* of Fox Lake for 50 years of service to his community.

Dr. T. C. Davis, Beaver Dam, president of the Dodge County Medical Society, presented Doctor Elliott with an award in the form of a golden key especially engraved for the occasion.

Chippewa Falls Hospital Accredited

Dr. C. B. Hatleberg, Chippewa Falls, president of the medical staff of St. Joseph's Hospital, Chippewa Falls, advises that full accreditation of the hospital has been received from the Joint Commission on Accreditation of Hospitals. The hospital, surveyed on May 2, 1955, is one of 1,385 hospitals in the United States and Canada surveyed for full accreditation. Of this number 922 were accredited.

Burlington Hospital Elects Officers

When the medical staff of the Burlington Memorial Hospital, Burlington, met on June 14, officers for the year 1955–56 were elected as follows:

President—*Dr. L. W. Erickson*
Vice-President—*Dr. J. D. Van Liere*
Secretary–Treasurer—*Dr. Leo Kempton*

All these physicians are from Burlington.

Dr. Robert Taylor Speaks at Owen

Dr. Robert Taylor of Marshfield addressed a gathering of the Withee Lions and Owens Kiwanis club members at Owen on June 27. The subject of his talk was "Hypertensive Blood Vessel Disease." *Dr. J. W. Johnson* of Withee introduced the speaker.

Doctor Livingstone of Hudson Honored

Having served 50 years in the medical profession, *Dr. J. W. Livingstone* of Hudson was honored by his community on June 2 and was presented with a check from the community. City Attorney John D. Heywood and Mayor George Madison presented the

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doctor with a framed resolution commending his faithful service.

Doctor Livingstone is an honorary staff member of the Hudson Memorial Hospital and of St. John's and St. Joseph's hospitals in St. Paul.

Doctor Pawsat Appointed to Health Committees

Dr. E. H. Pawsat of Fond du Lac has been appointed to a five-year term as a member of the Joint Committee on Health Education Problems of the National Education Association and the American Medical Association. He has also been named by Governor Walter J. Kohler to a two-year term on the Wisconsin Committee on Children and Youth.

Doctor Pawsat was recently voted into membership in the Milwaukee Pediatric Society.

Doctor Heinz Opens Office at Sheboygan

Dr. Harold N. Heinz has opened an office for the general practice of medicine at Sheboygan. He received his medical education at Marquette University School of Medicine, graduating in 1946. From July, 1948, to May, 1953, he served as an industrial physician at the Kohler Company, after which he served two years as a captain in the medical corps of the U. S. Air Force. He was discharged from service in May of this year.

Doctor Turcott Leaves for Army Duty

Dr. Robert A. Turcott of Lake Mills has reported for military duty at Brooke Army Medical Center, Fort Sam Houston, San Antonio, Texas. He will be stationed there until the end of August, when he will be assigned to a permanent base for the remainder of his two years' Army duty.

Doctor Nilles to Practice at Two Rivers

Dr. John E. Nilles, who practiced at Mishicot from December, 1952, to April, 1953, has associated in the practice of medicine with *Dr. R. E. Martin* at Two Rivers.

Doctor Nilles served with the medical corps of the U. S. Army from April, 1953, to May, 1955. He is a 1951 graduate of Marquette University School of Medicine and completed his internship at Mercy Hospital at Oshkosh.

Doctor Kuehn Serving in Germany

Dr. A. E. Kuehn, who formerly practiced at Viroqua, has advised that since February he has been commanding officer of the 128th Evacuation Hospital at Landstuhl Medical Center in Germany. On August 1 he moved to Stuttgart, Germany, and may be addressed at Army Post Office 154, New York, New York.

Doctor Kuehn expects to return to his practice in Viroqua in about a year.

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Barron Doctors Move to California

Dr. G. A. Fostvedt and his wife, *Dr. Lucille M. Radke*, who practiced at Barron for the past nine years, have sold their practice to *Dr. Dean Hammond* of Chetek. The Fostvedts left for California the latter part of July to make their future home in the West.

Dr. Robert Schroeder Returns to Fond du Lac

Dr. Robert W. Schroeder, who recently completed a residency at Milwaukee Children's Hospital, has associated with the Wiley–Smith Clinic at Fond du Lac. His practice will be limited to the diseases of children.

THIRD AND TWELFTH DISTRICTS NEWS

Dr. W. B. Hobbins Returns from Service

Dr. William B. Hobbins has rejoined the medical group of Drs. Cooksey, Sisk, Wear, Harper, and Parks at 1 South Pinckney Street, Madison, after two years' service in the Army. He was stationed at Fort Carson, Colorado, as chief of general and thoracic surgery.

Dr. James McIntosh Associates with Madison Urologist

Dr. James F. McIntosh, who recently completed a residency in urology at University Hospitals, Madison, has associated with *Dr. A. P. Schoenenberger*, Madison, in the specialty of urology.

Doctor McIntosh graduated from the University of Wisconsin Medical School in 1947 and interned at New Orleans, Louisiana. He was called to duty in the Navy in 1950 and spent most of his service on a Navy hospital ship during the Korean War.

Doctor Sweeney Resumes Beloit Practice

Dr. Thomas C. Sweeney has returned to his practice at Beloit after serving two years in the Army at Buffalo, New York. Prior to his military service, he practiced at Beloit for 10 years. He is a member of the Beloit Hospital staff.

Doctor Roisum Opens Practice in Psychiatry

Dr. Bryant H. Roisum, who recently completed a residency in psychiatry at University Hospitals, Madison, has opened an office at 2705 Cornell Court, East, Madison. He graduated from the University of Wisconsin Medical School in 1945.

Dr. George Griffin at Madison

Dr. George D. J. Griffin has opened his office in the Tenney Building at Madison for the practice of general and pediatric surgery.

Born in Chicago, Doctor Griffin attended Loyola Medical School there and completed his internship at Cook County Hospital. In 1948 he began a five-year postgraduate training course in surgery at the Mayo Clinic in Rochester, Minnesota. He served in the Air Force during the Korean War.

Dr. Philip Piper at Madison General Hospital

Dr. Philip G. Piper, Madison, has been named administrative director of laboratories and assistant pathologist at Madison General Hospital. He is associated with *Dr. Lester E. McGary*, director of laboratories and chief pathologist at the hospital.

Doctor Piper graduated from the University of Wisconsin Medical School and served his internship at Milwaukee Hospital. His residency training was obtained at the University Hospitals and Madison General Hospital. He served in the Army Medical Corps for four years.

Doctor Rotter Returns to Practice

Dr. Royal Rotter has resumed his practice of internal medicine and hematology at 1901 Monroe Street, Madison. For the past two years he served in the Army Medical Corps and was chief of medical services at Ft. Lawton Army Hospital, Seattle, Washington. Doctor Rotter graduated from the University of Wisconsin Medical School in 1947; interned at Michael Reese Hospital, Chicago; and completed his residency in internal medicine at the University Hospitals, Madison.

Doctor Kring Joins Quisling Clinic, Madison

Dr. Gerald G. Kring, a graduate of Northwestern University Medical School in 1948, has joined the staff of the Quisling Clinic, Madison, in the specialty of obstetrics and gynecology. He was recently discharged from the Army Medical Corps. During his period of service he was chief of obstetrics and gynecology at the U. S. Army Hospital, Ft. Monroe, Virginia.

Doctor Kring received his specialized training at St. Francis Hospital, Chicago, and at the University of Illinois Medical School.

Milwaukee Physicians Appointed to Marquette Staff

Drs. William M. Pfeifer, Marvin Wagner, and *C. Hugh Hickey* have received appointments to the faculty of Marquette University School of Medicine.

Doctors Pfeifer and Wagner will serve as clinical instructors in surgery, and Doctor Hickey will be a clinical instructor in orthopedic surgery.

Doctor Redlin Has New Associate

Dr. James V. Pilliod, Milwaukee, has opened his office for the practice of internal medicine in association with *Dr. Russell Redlin* at 8320 West Bluemound Road, Milwaukee. Doctor Pilliod recently

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

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Brown, H. W.: J. Pediat. 45:419, 1954.

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completed his residency in internal medicine at Milwaukee County General Hospital. He has been appointed a clinical instructor in the department of medicine at Marquette University School of Medicine.

Milwaukee Physicians Receive Civic Awards

When the Milwaukee Vocational School's Technical Institute held graduating ceremonies on June 9, two Milwaukee physicians were presented with civic awards. They were *Dr. Laurie Lee Allen*, who has been a lecturer for 17 years at the school's nursing school, and *Dr. Max J. Fox*, medical director of Southview Hospital, Milwaukee.

A similar award was granted to Mr. Voyta Wrabetz, chairman of the State Industrial Commission.

Dr. John P. Docktor Member of Specialty Society

Dr. John P. Docktor, who recently established his practice at 161 West Wisconsin Avenue, Milwaukee, was chosen for membership in the American Society of Maxillofacial Surgeons at its recent meeting in Louisville, Kentucky. He is the second Wisconsin surgeon to be so honored by this society. Membership is restricted to a limited number of men who hold both dental and medical degrees. Doctor Docktor is a Diplomate of the American Board of Plastic Surgery.

SOCIETY RECORDS

New Members

R. F. Sorensen,** General Delivery, Rudyard, Michigan.

G. H. Franke,** U.S.S. Johomes Jefferson, % F.P.O., San Francisco, California.

E. J. Miller,** 3314 Heyward Street, Columbia, South Carolina.

N. E. Pond,** Lackland Air Force Base, San Antonio, Texas.

D. C. Bleil, Indianapolis General Hospital, Indianapolis, Indiana.

H. J. Watson, Jr., 4262 North 45th Street, Milwaukee.

R. J. Trettin, 2540 North 45th Street, Milwaukee.

Ernst Schmidhofer, Milwaukee County Asylum, Milwaukee.

A. S. Hartman, Veterans Administration Hospital, Wood.

Morris Gelfman, 9035 Watertown Plank Road, Milwaukee.

Marvin Glicklich, 6233 West Locust Street, Milwaukee.

Lucille B. Glicklich, 6233 West Locust Street, Milwaukee.

C. P. Erwin, 333 North 75th Street, Apartment 3, Milwaukee.

N. H. Engbring, 2924 South 71st Street, Milwaukee.

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P. J. Lawler, 8472 Ravenswood Circle, Milwaukee.

U. L. Meeter, 625 57th Street, Kenosha.

J. J. Meaney, 6820 14th Avenue, Kenosha.

J. W. Manier, Graduate Hospital, Department of Gastroenterology, University of Pennsylvania, Philadelphia, Pennsylvania.

E. F. Weir, Oconomowoc.

H. J. Colgan, Winnebago State Hospital, Winnebago.

L. B. Torkelson, Baldwin Clinic, Baldwin.

A. B. Kuritz, 208 East Wisconsin Avenue, Milwaukee.

R. W. Cromer, 824½ Fifth Avenue, Antigo.

Changes of Address

W. C. Harris, Milwaukee, to 3821 Maryland Avenue, Racine.

J. C. Curry, Milwaukee, to 2003 Lewis Mountain Road, Charlottesville, Virginia.

H. F. Bischof,** Lake Geneva, to 6520th U.S.A.F. Dispensary, Laurence G. Hanscom Field, Bedford, Massachusetts.

C. M. Strand, Westby, to 464 North Story Parkway, Milwaukee.

J. J. Brook, Jr., Albuquerque, New Mexico, to 8700 West Wisconsin Avenue, Milwaukee.

G. J. Hugo, Campbell, California, to 300 North Vega Street, Alhambra, California.

P. R. McCanna, Marinette, to 818 South Wallcott, Chicago, Illinois.

Royal Rotter, Seattle, Washington, to 1901 Monroe Street, Madison.

R. F. Finegan, Madison, to 737 Reba Place, Apartment 1A, Evanston, Illinois.

E. J. Kiefer, Neenah, to 2460 North 96th Street, Wauwatosa.

L. W. Smith,** Racine, to 417 Boxwood Road, Oceanside, California.

D. V. Clatanoff, Madison, to 276 Lexington Street, Watertown, Massachusetts.

R. C. Olson, Green Bay, to 1713 22nd Avenue, Menominee, Michigan.

F. A. Brown, Madison, to 3650 Clairemont Drive, San Diego, California.

M. W. Nelson, Milwaukee, to 312 Seventh Street, Racine.

J. W. Pick, West Bend, to 411 East Mason Street, Milwaukee.

V. J. Burch,** Racine, to 6103 S.U. Br. U.S.D.B., Lompoc, California.

J. J. Brenner, Adams, to 2011 Mayflower Drive, Middleton.

T. C. Sweeney, Williamsville, New York, to 400 East Grand Avenue, Beloit.

J. E. Nilles, Camp Haven, Wisconsin, to 1806 Washington Street, Two Rivers.

D. R. Korst, Madison, to Veterans Administration Hospital, Ann Arbor, Michigan.

M. A. Cornwall, % Postmaster, New York, to Hudson.

** Military Service.

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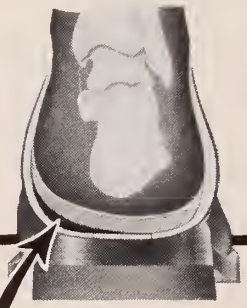

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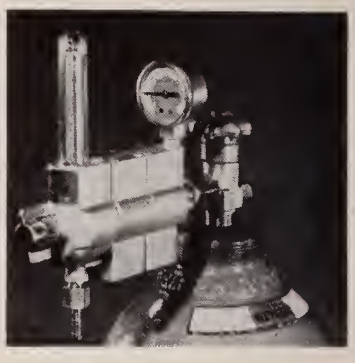

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H. B. Haley, Boston, Massachusetts, to 818 Columbian Avenue, Oak Park, Illinois.

W. B. Hobbins, Colorado Springs, Colorado, to 1 South Pinckney Street, Madison.

L. M. Gorenstein, Speedway, Indiana, to Colorado University Medical Center, Department of Psychiatry, Denver, Colorado.

H. F. Burich, La Crosse, to 915 Third Avenue, S. E., Rochester, Minnesota.

** Military Service.

DEATHS

Dr. James Virgil May, 79, Marinette physician, passed away at his home on June 12 following a heart attack.

He was born on January 4, 1876, in Russell, Iowa, and obtained his medical education at the College of Physicians and Surgeons, St. Louis, Missouri, graduating in 1900. He practiced at Wautoma, Wisconsin, from 1900 to 1904 and at Redgranite from 1904 to 1906, then moving to Marinette.

Doctor May specialized in the treatment of conditions of the eye, ear, nose, and throat. In 1925 he became a Diplomate of the American Board of Ophthalmology. He was also a member of the American Academy of Ophthalmology and Otolaryngology, the Central Wisconsin Society of Ophthalmology and Otolaryngology, the Marinette–Florence County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He served as president of his county medical society on two occasions, one term for a period of 10 years.

On November 17, 1954, Doctor May was honored by the medical societies of Marinette–Florence and Menominee counties and their auxiliaries for his 50 years of service as a physician. On this occasion he received a plaque from the Marinette–Florence County Medical Society and tributes from local and state medical and civic leaders.

Surviving are his widow, Viola; two sons, James B., of Hollywood, California, and George D., of San Francisco; five brothers; and three sisters.

Dr. John William Smith, 64-year-old Milwaukee dermatologist, died at his home on June 19.

Doctor Smith was born on April 14, 1891, in Madison, Wisconsin. He was graduated from Marquette University School of Medicine in 1915 and interned at Milwaukee County Hospital. He served a one-year residency from 1916 to 1917 at Milwaukee County Hospital, Emergency Unit.

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After doing postgraduate work at the New York Skin and Cancer Hospital and at Vienna, Austria, Doctor Smith became a member of the American Academy of Dermatology. He formerly was an instructor in dermatology and later an assistant clinical professor of dermatology at Marquette University School of Medicine, resigning the latter post in 1943 to accept an appointment on the State Board of Medical Examiners. He served on the Board for three terms, and in 1949 and 1950 was its president.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association and had served as treasurer of the State Society and as delegate to the House of Delegates of the American Medical Association.

Surviving him are two sisters, Miss Bessie Smith and Miss Genevieve Smith, with whom he lived.

Dr. William Joseph Murphy, Milwaukee, died at a Milwaukee hospital on June 13.

Born on April 3, 1886, he was 69 years of age at the time of his death. He received his medical degree from Marquette University School of Medicine in 1909 and interned at Dayton, Ohio, for a year. He then had a three-year residency at Leavenworth, Kansas, before establishing his practice in Milwaukee in 1913.

Doctor Murphy did postgraduate work at City Hospital, New York City, and at the Cook County Hospital at Chicago. He also studied urology at Johns Hopkins Medical School, Baltimore, Maryland. He formerly was a medical instructor in urology at Marquette University School of Medicine for a period of five years. In the 1940's he served as chief of staff of Misericordia Hospital.

He served in the medical corps during World War I from November, 1918, to May, 1919. He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, the Wisconsin Urological Society, and the state and national chapters of the Academy of General Practice.

Doctor Murphy is survived by his widow, Vivian.

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The Journal Bookshelf

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All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal "Bookshelf,"* are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry, and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

The Hepatic Circulation and Portal Hypertension. By Charles G. Child, III, M. D., professor of surgery, Tufts College Medical School; chairman, department of surgery, New England Center Hospital; formerly associate professor of clinical surgery, Cornell University Medical College; attending surgeon, New York Hospital. Philadelphia and London, W. B. Saunders Company, 1954.

Doctor Child and his associates have done an excellent job and supplied a real need in compiling and evaluating the great mass of data which has appeared in the literature on the subjects of the hepatic circulation and portal hypertension. To this they have added generously from their own experience in the field.

Normal and abnormal anatomy and physiology and experimental and clinical surgery are exhaustively reviewed. The illustrations are numerous and of good quality. The bibliography is extensive. This book will be of great value to the surgeon, internist, or investigator working in its area. It will have very limited interest for those not so concerned.—J. L. S.

Essentials of Medical Research. By Wallace C. Marshall, M. D., New York, Vantage Press, Inc., 1953. Price $3.00.

Essentials of Medical Research represents a very well-written attempt on the part of a practicing physician to stimulate other physicians to make a contribution to medical literature through the performance of original research. This interesting volume takes up nearly every conceivable angle of planning, financing, and executing a research problem. Finally, it tells how to prepare a report on such a problem in the form of a paper, including hints as to the contacts one might make to assure publication. The book is brief, concise, and extremely readable. It would make most physicians pause and reflect upon the challenge that a research problem would add to their everyday activities.

There are times when Doctor Marshall tends to oversimplify his subject; and in his zeal to sell research activities to his colleagues, he becomes a bit too much of the "promoter." Also, the extreme secrecy which he emphasizes concerning the relationship of the doctor and the lay public is now a bit outmoded. As a matter of fact, even the Code of Ethics of the American Medical Association now permits more realistic relationships with the lay public and the lay press.

Of special interest and merit are the continuous admonitions to assure oneself that he is being scientifically truthful, the specific hints the author gives about the reading of a paper during a scientific program, and the very objective approach which is suggested as the best method of reviewing scientific literature on any particular subject. Interesting, too, are the author's remarks concerning the financing of medical research and the possible sources of funds for such research.

This book is recommended as excellent reading for any practitioner, provided he is warned that it will probably stimulate him to consider the addition of further activities to his already busy day.—R.C.P.

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OF THE
STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON PREPAID PLANS

New Blue Shield Representative

Frank T. Thatcher has been named district sales coordinator for the Appleton office of Wisconsin Physicians Service, the Blue Shield Plan of the State Medical Society of Wisconsin. His office is located at 1023 Irving Zuelke Building.

THATCHER

Thatcher will service the Fox River Valley area and cities in northeastern and north central Wisconsin.

His duties will be to assist in the conservation of existing Blue Shield business in this area, to promote the sale of Blue Shield contracts to new groups in cooperation with Blue Cross representatives, to encourage existing groups to purchase additional Blue Shield coverage in the form of riders, and to assist and advise physicians in this area on Blue Shield matters.

The position previous to Mr. Thatcher's arrival was held by John LaBissoniere, who has been named field representative for the State Medical Society. He will work out of Madison.

Thatcher has had nearly 10 years' experience as a sales representative for a number of pharmaceutical firms. Previously, he served in the Army Signal Corps.

He is a native of Milwaukee. He attended the University of Wisconsin, City College of New York, and Marquette University.

Thatcher is married, and his wife and three children are now living in Milwaukee. They expect to move to Appleton soon.

Urge 11,000 to Buy Both Plans

A special effort is being made to encourage some 11,000 "Blue Cross-only" contract holders to add Blue Shield coverage to their protection. All of these now have non-group coverage only with Blue Cross. Those who live outside Milwaukee County are being offered Wisconsin Physicians Service with their August quarterly billings. Those within the county are offered Surgical Care with the same billing.

Vernon County Enrollment

In mid-August, an intensive effort was made to enroll non-group and small group business in Vernon County. Two quarter-page newspaper ads appeared in the major weeklies, and thousands of families were contacted by direct mail. Viroqua Hospital served as the enrollment headquarters.

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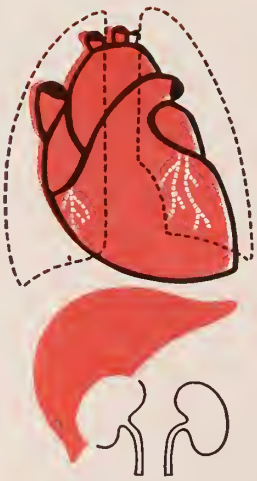

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CORRESPONDENCE

Dear Sir:

Here is a summary of the results obtained from the various lists of prospects the Medical Society's placement service so kindly forwarded to us. First, let me say that we did not have to contact nearly as many doctors as we first anticipated. We operated as follows: A three-man committee was named to screen the lists, and each man selected three or four doctors whom he considered the most likely to consider a location in Kewaunee. I then wrote letters and sent descriptive brochures of our community to each of the prospects with the intention that if the first round of inquiry did not bring results the process would be repeated.

Actually, we never got beyond the first round of correspondence because it seemed we always had an excellent prospect available. In fairness to the doctors who had shown an interest and to keep ourselves from becoming too involved, we refrained from making too many contacts until it was definitely established that those who had shown interest had changed their plans.

We have been successful, through your cooperation, in interesting Dr. Patricia and Dr. Andrew Lanier of Fulton, Missouri, in completing plans for location of their profession in Kewaunee. Everyone in town who met them liked them very much, and they are enthusiastic about our community. We assisted in arranging for them to purchase a fine home in Kewaunee and in helping them to find temporary office quarters. Meanwhile, a local real estate dealer is arranging to build a new office for them to their own plans and specifications on a "rent with option to buy" basis.

May I thank you again for your excellent cooperation. I have been Secretary of the Kewaunee Chamber of Commerce for the last seven years. During that time we have completed many projects of which our officers and directors were more or less justifiably proud. Yet in each case there was always a segment of local population that did not agree with us. I can truthfully say that this is the first time in my experience in Chamber of Commerce work where our action has met with universal popular approval. You can judge by this what the coming of two more doctors means to Kewaunee, and I hope you will share with us the rewarding satisfaction we feel.

Yours very truly,

/s/ E. F. STIKA, *Secretary*
Kewaunee Chamber of Commerce

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PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

WANTED: General practitioner for rural community. Large practice, grossing $20,000 per year. Large, modern, fully equipped office with laboratory, including G. E. x-ray with fluoroscopy, new G. E. diathermy and E. C. G. equipment. Available on extremely liberal terms. Previous physician now in medical research. Young dentist and pharmacist in same building. Address replies to Mr. Edward Kraemer, Plain, Wis.

PHYSICIANS WANTED: The Mendota State Hospital has temporary staff positions available for young doctors awaiting military or residency assignments. Contact Dr. A. Soucek, Assistant Superintendent, Mendota State Hospital, Madison 4, Wis.

PHYSICIAN-SURGEON WANTED for industrial community serving 3,000 people within 20-mile area. Will lease attractive doctor's residence and fully equipped first-aid hospital for private practice. Estimated net income of $10,000 for first year, and practice should increase each year thereafter. Available for immediate occupancy. Phone or write Goodman Lumber Company, Goodman, Wis.

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FOR SALE: Combination house, office, and practice. Excellent location in north central Wisconsin, in territory including several towns and villages without a doctor. Practice established over 20 years. Modern home and office; office completely furnished. Civic groups will give support. Owner selling because of age and poor health. Address replies to Box 587 in care of the Journal.

FOR SALE—200 milliampere, fully rectified, Picker Century radiographic and fluoroscopic combination x-ray unit with motor driven tilting table. Also two-drawer filing cabinet for x-ray storage. Excellent condition. $2,000. Address replies to Box 613, in care of the Journal.

FOR SALE: Abrahamson Sedimentation Tube outfit with base and assembly. Address replies to Box 600 in care of the Journal.

WANTED: Resident physician, full or part time. Call or write Medical Director, Capitol Hospital, 1971 W. Capitol Drive, Milwaukee, Wis., Hi. 4-1400.

WANTED: Young general practitioner to associate in general practice. No immediate investment required. Opportunity to take over entire practice as soon as desired. In village of 1,200 population. Excellent hospital in nearby city. Address replies to Box 602 in care of the Journal.

FOR SALE: Office equipment, complete, for 5 rooms. Includes portable (Fisher) x-ray machine, examining table, and new waiting room set. Address replies to Box 603 in care of the Journal.

FOR RENT: Office space for general practitioner. Desirable residential location. Ample parking space. Office will be arranged to suit tenant. Ample space for consultation room and 3 examining rooms. Write E. J. Kilkelly, Kilkelly's Rexall Drug Store, 7505 Sheridan Road, Kenosha, Wis.

WANTED: Young general practitioner to associate in established general practice located in large southeastern Wisconsin city. Write full particulars in first letter. Salary to start. Address replies to Box 606 in care of the Journal.

FOR SALE OR RENT: Home above large, five-room, well-equipped office with prosperous general practice. All on large landscaped lot (Wauwatosa, a Milwaukee suburb) just 10 minutes from the Braves' stadium and State Fair Park. Lease, $300 per month with option, $20,000 to buy. Owner specializing. Phone Bluemound 8-4353 or address replies to Box 605 in care of the Journal.

FOR SALE: Office equipment and furniture. Owner leaving for residency. Contact J. N. Dockery, M. D., 3333 Erie Street, Racine, Wis.

FOR SALE BY WIDOW OF PHYSICIAN: Equipment including instruments, examining table, hyfrecator, scales, etc. Purchased within last year. Contact Mrs. Louis Reis, 701 Seneca Place, Madison, Wis.

LABORATORY AND X-RAY TECHNICIAN (male) with 7 years' experience in hospital, clinic, and sanatarium desires position in southern Wisconsin. Can furnish excellent references. Address replies to Box 608 in care of the Journal.

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MICROSCOPE WANTED for medical student. Phone or write, giving description, to Dr. C. C. Gascoigne, 431 Audubon Rd., Kohler, Wis.

LOCUM TENENS POSITION DESIRED by second-year radiology resident. Address replies to Box 614 in care of the Journal.

FOR SALE: 40-90 Meyer x-ray complete with table. Excellent condition. Contact Dr. A. F. Ottow, 550 East Grand Ave., Beloit, Wis. Phone Emerson 2-3342.

FOR SALE by widow of specialist, instruments used in E. E. N. T. practice. Many of them purchased in Europe. Some office equipment and medical books also available. Very reasonable. Address replies to Box 615 in care of the Journal.

PHYSICIAN with at least 2-years' pediatric training needed in maternal and child health program at salary ranging from $7,913 to $9,142. Five-day week, pension, civil service appointment. Address replies to Dr. E. R. Krumbiegel, Milwaukee Health Department, City Hall, Milwaukee, Wis.

FOR SALE: Office furnishings and equipment, including x-ray, diathermy, and drug inventory, in community of 2,250. Physician moving out of state, and replacement is needed. Address replies to Box 616 in care of the Journal.

FOR SALE: General practice in rapidly growing Green Bay, Wis. Choice rental location in heart of city. Address replies to Box 617 in care of the Journal.

FOR SALE: Office equipment, instruments, and medical library of the late Dr. James V. May, eye, ear, nose, and throat specialist in Marinette for over 47 years. Inquire of Mrs. James V. May, 1421 Grant Street, Marinette, Wis.

FOR SALE by widow of physician: Office equipment and office space; four rooms in heart of Boscobel; $30 a month rent, heat in winter extra; air-conditioned for summer. Previous physician in general practice and had equipment for fitting glasses. Contact Mrs. C. S. Hayman, 938 Wisconsin Avenue, Boscobel.

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The Placement Service of the State Medical Society has registered with it a number of specialists in various fields as well as general practitioners. Contact the Placement Service by writing Box 1109, Madison, Wisconsin.

THE WISCONSIN MEDICAL JOURNAL

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Volume 54 SEPTEMBER 1955 Number 9

Adenomas and Hemorrhoids: Problems of Rectal Bleeding*

By ROBERT TURELL, B. S., M. D., F. A. C. S.
New York, N. Y.

INTRODUCTION

SUCCESSFUL management of bleeding from anywhere in the alimentary tract depends primarily on the discovery of its cause, which on occasion may be difficult to establish. In some persons the causative factor is never discovered despite repeated intensive examinations. This cryptogenic bleeding is surmised to arise from rapidly healing ulcerations.

Blood originating from a lesion in the descending or sigmoid colon, if retained in the rectum long enough, may appear dark, resembling blood coming from a lesion in the upper intestinal tract or stomach, while in the case of hypermotility of the intestines, blood coming from a gastric or duodenal lesion may occasionally be bright red. In infants about three cubic centimeters of swallowed blood may produce tarry stools within eight hours, while in adults tarry stools may be formed from about fifty to one hundred cubic centimeters of blood. Blood may appear unaltered or altered (decomposed). The former is recognized grossly or microscopically while the latter (also designated as melena) is recognized microscopically or by means of chemical tests.[1] A word of caution should be given: Brightly colored ingested substances such as ink, paints, phenolphthalein, red jello, or beets may sometimes cause red discolorations of the stool and thus mimic blood in the feces.

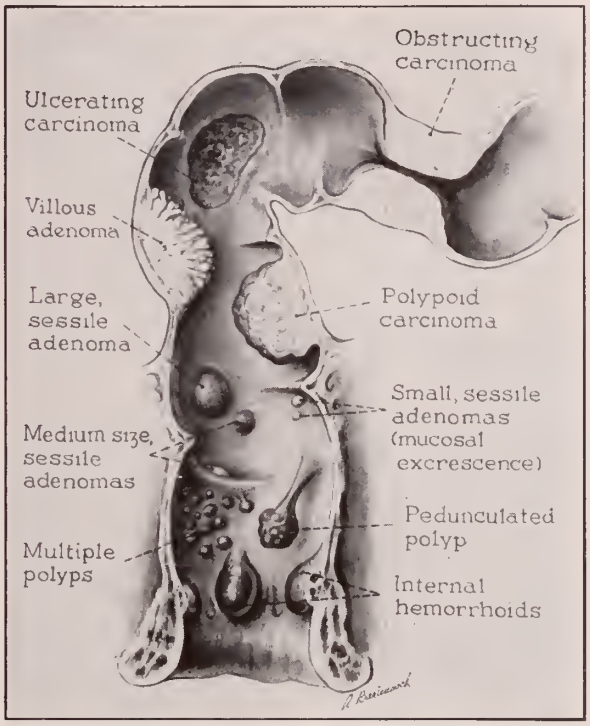

Fig. 1—Important lesions that may produce bleeding via the anal canal (Turell, R., in *CA*, May, 1954).

Hemorrhoids as a cause of bleeding have sometimes been either underestimated or exaggerated. The mere anatomic presence of hemorrhoids is often interpreted as a cause of bleeding even if none is demonstrated. I have seen cases of rectal cancer that could be palpated digitally and yet were missed because the bleeding was attributed to the readily presenting, large but nonbleeding hemorrhoids. Moreover, in some of these instances the piles had been treated surgically or conservatively for some time before the cancer was detected. The coexistence of hemorrhoids with cancer and/or adenomas of the large and, occasionally, the small intestine, though frequently stressed, is still forgotten or overlooked.

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* Presented at the One Hundred and Fourteenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, May 3, 1955. Part of the material forms the basis of an exhibit that was shown at this Annual Meeting and at that of the American Medical Association at Atlantic City in June, 1955. This lecture was illustrated by means of lantern slides. The section on adenomas is complementary to another paper on this subject that is to appear in the *Surgical Clinics of North America*, October, 1955.

Bleeding from the rectum is usually caused by lesions within the alimentary tract, although extraintestinal and systemic disorders may also be responsible. Of the colorectal causes, internal hemorrhoids are the most frequent, while cancer is the most important. Adenomas, which in a statistical sense are precancerous lesions, have not always been accorded due consideration. (Fig. 1) Some of the more common systemic disorders that may be responsible for bleeding from the rectum are (1) blood dyscrasias, the thrombocytopenic and nonthrombocytopenic (*e.g.*, Henoch's) purpuras, hemophilia, and leukemia; (2) deficiencies of vitamins C, K, and P; and (3) hypertension with or without arteriosclerosis.

Blood dyscrasias and vitamin deficiencies as causes of rectal bleeding are encountered quite frequently. I have 2 patients with thrombocytopenic purpura whose first demonstrable symptom was bleeding from the rectum; ecchymosis of the intestinal mucosa preceded that of the skin. Frequent episodes of thrombosis of internal piles without prolapse may be the first clinical clue to a blood dyscrasia.

It is surprising to note how seldom hemorrhoids or adenomas are thought of as a source of blood loss in cases of iron-deficiency anemia even when the anemia fails to respond to accepted antianemia treatment. As a result, slow and chronic bleeding from the internal hemorrhoids or adenomas that may cause anemia is often unrecognized, uninvestigated, and untreated. About ten such cases come under my surveillance yearly.

Each year during the past decade and a half, I have also encountered 3 to 4 patients, varying in age from 38 to 76 years, with symptoms of reduced blood volume due to blood loss; namely, weakness, palpitation, tachycardia, mild dyspnea, and occasionally precordial pain, who were considered to have heart disease. Some of these patients were suspected of having cardiac neurosis. The existence of varying degrees of progressive anemia ultimately leads to more comprehensive examinations, including a survey of the alimentary tube that eventually reveals the internal hemorrhoids or adenomas as the sole source of the occult or gross, but unreported, blood loss. It is not generally appreciated that loss of blood resulting from adenomas is usually intermittent, slow, and small in amounts rather than profuse or sudden, although on occasion the bleeding may be profuse. It is, however, generally conceded that in adults loss of blood is essential in the development of iron-deficiency anemia. Following either hemorrhoidectomy or sclerotherapy, or the disposition of the adenomas, the anemia is corrected and the symptoms suggestive of heart disease disappear.

From the foregoing it is apparent that bleeding from the rectum, whether occult or gross, altered or unaltered, demands a comprehensive systemic and local investigation. The survey should include a detailed general history and a comprehensive physical examination, plus peripheral blood studies of the patients. Other special tests such as a bleeding and clotting time, capillary fragility test, and a cardiogram are advisable in selected instances. The local survey comprises a stool examination for evidence of blood and parasites, and endoscopy and radiography in all cases regardless of age. Sigmoidoscopy is preferably done without preliminary preparation in order to detect blood that may be coming from above the reach of the scope and which might be washed away by the enema. If this examination is unsuccessful and time is of the essence, an enema consisting of about 100 cc. of a proprietary solution containing 16 Gm. of a sodium biphosphate and 6 Gm. of sodium phosphate (Fleet) is given, and endoscopy is repeated within 30 minutes. Otherwise, this or a conventional tap water enema is given; the latter is taken about four hours before endoscopy. Radiography, utilizing the newer special techniques, is employed in all cases of gross or occult bleeding and is repeated whenever doubtful shadows are discernible.

Sigmoidoscopy does not require a proctologist; many progressive internists, general practitioners, and general surgeons have trained themselves to perform sigmoidoscopy, which can be mastered only with practice. Endoscopy for a distance of at least 15 cm. from the anal verge should be made a routine part of every physical examination. The scope should be inserted into the rectum gently and advanced equally gently under visual guidance only. Endoscopy should be discontinued promptly whenever the lumen of the bowel ahead of the scope is obscured either by feces, blood, or an impassable lesion, or if the patient is unduly

uncooperative or restless.[2] In juvenile patients special caution should be exercised because of the peculiar arrangement of the rectum and sigmoid colon with its sharp angulations, and the fragility of the intestinal wall.[3]

All suspicious and grossly apparent accessible lesions should be biopsied and the specimens subjected to histopathologic examination. In the case of adenomas the specimen should include the basement membrane in order to detect any invasion. This procedure is designated as "total biopsy" and connotes the removal of the entire polyp at its base, in one piece or in several large segments. Biopsy should be performed only by those capable of caring for possible complications such as profuse bleeding.

HEMORRHOIDS

Etiology

Hemorrhoids have been mentioned frequently in Biblical writings and in other historic works and have exerted an influence on man throughout the ages. The etiology of hemorrhoids remains obscure; numerous causes have been suggested. Lack of substantial anatomic support in the submucosa for the hemorrhoidal veins plus the factor of gravity favoring stasis (particularly when the subject is in the erect position), and a familial tendency are some of the important predisposing and/or causative factors. As my experience has broadened, I have come to question seriously whether infection of the perianal structures is of etiologic importance. Nor can one accept the concept that hemorrhoids are a collagen disorder, as Klemperer has shown that collagen diseases are characterized by generalized and not by local alterations of extracellular components of connective tissue. Hemorrhoids are certainly not a systemic disease. In recent years I have observed that occupational strain is a significant precipitating factor in the causation of prolapse of internal hemorrhoids in some cases, and an aggravating factor to existing piles in numerous instances.

Treatment

In spite of a voluminous literature the merits and demerits of injectional sclerosing and surgical therapies are still poorly understood by most of the profession. This is largely the result of overemphasis on injectional therapy by those incapable of performing surgical procedures and of undue stress on the operative approach by surgeons who are unacquainted with the conservative methods of treatment. Anyone who undertakes to treat hemorrhoids should be capable of performing both forms of therapy.

In my experience the hemorrhoids in over 20 per cent of the patients were so nearly symptomless as to require no therapy; in a nonspecialistic practice this incidence must be much higher.

Injectional sclerosing therapy was effectively employed in over 30 per cent of patients. These individuals had small to medium-sized bleeding internal piles with or without spontaneously reducible prolapse. Prior to injectional therapy it is imperative to establish the absence of active or latent inflammatory disease of the anorectocolonic tube. Sclerotherapy, by producing a sterile inflammatory reaction at the sites of injection, causes a chemical thrombosis of the vessels which is followed by sclerosis and finally by fibrosis. About sixty-five per cent of my patients usually have remained symptom-free during a follow-up period of observation of over three years. Reinjection was required in over 30 per cent of patients because of the recurrence of bleeding. Sclerotherapy apparently does not produce a permanent cure. A cure depends primarily upon (1) the fate of fibrosis, which is a biologic unpredictability, and (2) the elimination of the causative or precipitating factors, which have existed prior to the institution of sclerotherapy, when these are ascertainable. Properly performed injectional therapy should not produce serious complications (*e.g.* severe ulceration, suppuration, hemorrhage, and irreducible prolapse).

Forty per cent of patients required hemorrhoidectomy. They had either large internal or mixed hemorrhoids that caused bleeding, pain, or protrusion, or a combination of these symptoms.

The remaining patients (about ten per cent) either were borderline problems or had concomitant systemic disease that justified a trial of nonsurgical therapy. However, a study of 67 such patients with systemic disease on whom I have eventually performed hemorrhoidectomies following unsuccessful injectional sclerosing therapy has convinced me (as well as the patients) of

the superiority of surgery where clear-cut local indications for hemorrhoidectomy exist. This conclusion was reinforced after treating by injection a still larger number of intelligent patients with mixed piles who, for business reasons, were unable to undergo hemorrhoidectomies at the time of their initial consultation. All of these patients expressed their preference for the operation.

HEMORRHOIDECTOMY

The techniques of sclerotherapy[4] and hemorrhoidectomy[5] have been described and illustrated. Of historic interest is the fact that the surgical technique introduced by Hippocrates (ligation and excision) still forms the basis of all modern techniques of hemorrhoidectomy.

Of the available techniques of hemorrhoidectomy, I prefer the open type of operation[5] without the use of packs, drains, or plugs; the wounds are merely covered with moist or nonadherent gelatin sponges that disintegrate spontaneously within 24 to 48 hours or are washed away in the first sit bath. This operation is singularly free from complications and does not cause undue postoperative pain or discomfort. Seldom are more than two injections of a narcotic drug required. However, the wounds are rarely healed completely in less than three weeks.

In the semiclosed operation, which is essentially the same as the open type except that the subcutaneous structures of the hemorrhoidal bed are closed approximating the skin but without suturing it, the wounds are completely healed in about two weeks. The incidence of induration with tenderness in the wounds is relatively low, and the induration usually resolves spontaneously or with the aid of antibiotics. In spite of the disadvantages I favor this type of hemorrhoidectomy whenever the saving of time is of paramount importance.

In the closed type of hemorrhoidectomy, all structures of the wounds, including the skin, are closed by suture following the excision of the hemorrhoidal mass. Following this operation about fifty per cent of the patients develop induration with considerable tenderness, which in a few instances eventuates in localized suppuration requiring drainage. Relative anal stenosis may occur in a number of patients. The decided advantage is the saving of time as the wounds in many patients are completely healed in less than 10 days. However, the closed type of hemorrhoidectomy is not a procedure to be recommended since its time-saving feature is offset by the high incidence of complications.

In recent years the profession has been flooded with literature concerning Efocaine and d-Tubocurarine for avoidance of pain following hemorrhoidectomy. My studies of Efocaine injected into the wounds at the conclusion of the operation in a controlled series of cases[6] showed no difference in the postoperative pain experienced by the treated and nontreated groups of patients as measured by the number of injections of a narcotic drug that were required after the performance of the open type of hemorrhoidectomy. The severity of postsurgical pain depends more on the type of hemorrhoidectomy performed and on the gentleness in handling tissues during operation than on the use or nonuse of a long-lasting anesthetic or other drugs. Furthermore, a number of troublesome side actions follow the employment of Efocaine;[7] like alcohol, Efocaine acts by destruction of the afferent nerves rather than by blocking the afferent impulses as procaine does.[8]

Neither does d-Tubocurarine appear to control posthemorrhoidectomy pain.[6, 9] In addition, in some patients the resultant muscular relaxation and pronounced impairment of muscle control interfere with the early ambulation of the patient and add new problems to the already overburdened and critically short trained nursing personnel. These calculated risks could not be justified even if this drug could effectively control postoperative pain, since after a well-performed open type of hemorrhoidectomy the pain, at worst, can be easily controlled with morphine, levorphan (Levo–Dromoran), or acetylsalicylic acid with phenacetin.

At best, Efocaine (or other long-lasting anesthetic drugs) and d–Tubocurarine (Tubadil) are only therapeutic crutches fostering a false sense of security and dependence on a drug; they are poor substitutes for good and gentle surgery.[6, 9]

Thus far, I have found no need for continuous caudal anesthesia produced by the ingenious method of implanting plastic tubes in the caudal canal through which an anesthetic drug can be periodically injected for the control of posthemorrhoidectomy pain.[10]

Postoperative Care

Proper postoperative care contributes to the success of the operation and the comfort of the patient. The patient is ambulated within 6 to 12 hours; hot sit baths are started within 12 to 24 hours. Moist compresses to the wounds are not used. A full diet with inclusion of two ripe bananas daily is offered to the patient within less than 12 hours. Liquid petrolatum in a dosage of 30 cc. daily is started on the first postoperative day and is continued for about five to thirty days. To date, in over 1,000 hemorrhoidectomies I have failed to note any of the alleged deleterious systemic effects, and I have not observed any interference with the effective healing of the wounds even in the occasional presence of oily leaks. Liquid petrolatum is at times combined with or replaced by a psyllium seed preparation of a hydrophilic colloid such as Metamucil. For patients with concomitant chronic constipation (whether of conviction or fact) a program of bowel re-education is started immediately after operation. This consists of reassurance, an adequate and nutritionally well-balanced diet, and the administration of liquid petrolatum or of psyllium seed preparation. Laxatives are avoided; however, when a laxative must be employed as a part of the bowel re-education program, I prescribe Senokot, a preparation of senna, in reducing dosages.

Postoperative digital examinations are begun between the fifth and seventh postoperative days when the wounds begin to epithelialize. These are repeated about every five days in order to promote healing of the wounds from the bottom out, thus avoiding bridging which may result in the formation of superficial fistulas. The lubricant used should be bland and free of anesthetic drugs because they are frequent cutaneous sensitizers causing annoying anoperianal dermatitis. More recently, the frequency of postoperative digital examinations has been curtailed considerably.

Postoperative Complications

Primary and secondary bleeding, suppuration, ulcerating unhealing wounds, impaction, and stenosis are the reported complications of hemorrhoidectomy. Postoperative anal stenosis occurs more often than the available literature would seem to indicate.[11] These complications seldom, if ever, follow a properly performed open type of hemorrhoidectomy.

Recurrence

The incidence of recurrence after a properly performed hemorrhoidectomy is uncommon. The pseudorecurrence consists of an incompletely removed primary pile, or of the enlargement of a secondary pile which at the time of the operation was of inconsequential size.

COMPLICATED PILES

I have treated over 100 cases of strangulated internal hemorrhoids associated with marked swelling of the external components and spasm of the anal sphincter muscles by immediate operation before the anatomic landmarks were markedly obscured by edema. Prompt operation eliminates protracted pain and restores the patient to early economic usefulness. Antibiotic therapy, *e.g.*, administration of oxytetracycline, is instituted before and continued after the operation as an additional safeguard against the remote possibility of the occurrence of pylephlebitis. Although some surgeons prefer conservative therapy and delayed operation, I have practiced early operation for over 15 years with gratifying results.

SIMPLE PILES—EXTERNAL PILES AND PERIANAL HEMATOMAS

External tabs or tags require no therapy. They are, however, excised when (1) they are the seat of ulceration or induration; (2) they are believed by the patient to interfere with postdefecatory hygiene; or (3) they are believed by the patient to be the seat of a malignancy (cancerphobia).

Perianal hematomas (external thrombosed piles) are treated conservatively when they are small to medium in size or soft in consistency. When large or hard, I prefer to remove them through an elliptical incision, removing all the overlying skin; mere incision and evacuation of blood clots is an inferior operation. All excised tissue should be examined histologically as unsuspected malignancies, notably melanotic or amelanotic melanomas, have been thus detected.

ADENOMAS

Incidence

Endoscopic studies[12] of 1,005 asymptomatic individuals under 45 years of age revealed an incidence of approximately two per cent of adenomas. When mucosal excrescences are included, the incidence rises to over 4 per cent. A similar study of older but

symptomatic persons (usually with bleeding from the rectum) revealed an incidence of over 7 per cent. The difference in the incidence is particularly marked in symptomatic and asymptomatic juvenile patients. While over 35 per cent of children with bleeding from the rectum harbored adenomas, sigmoidoscopy for a distance of over 15 cm. from the anal verge yielded only one adenoma in 105 asymptomatic juveniles between the ages of 6 and 16 years. Other authors, however, have found an identical incidence of adenomas in symptomatic and asymptomatic adults which varied from 5 per cent[13] to 12 per cent.[14] A similar discrepancy is noted in the reported incidence of adenomas observed in cancer detection clinics. One report records an incidence of 2.6 per cent;[15] another, an incidence of 17.2 per cent.[16] This last study also revealed a lower incidence of adenomas in people over 64 years of age than in those between 45 and 63 years. Necropsy studies have also revealed a wide discrepancy, varying from 2.6 per cent[17] to 68 per cent;[18] in the latter study a magnifying hand lens was used.

It appears that the high incidence of adenomas reported by some observers is due to the inclusion of minute sessile mammillations or areas of localized edema with or without mucosal hyperplasia. Some of these "polyps" are absent on succeeding examinations. Thus, 41 adenomas observed on one examination could not be found in subsequent examinations.[16] In another instance there was no evidence of the original adenomas in 4 out of 11 patients in the follow-up examinations.[13]

Family Tendency

In contrast to familial polyposis, a familial tendency toward the development of either single or several scattered discrete adenomas is as a rule not observed. However, my finding in 1941 of adenomas in 5 surviving members of one family whose parents had died of a questionable intestinal malignancy evoked some speculation. It was felt that a factor other than advanced age of these patients might be responsible for the preponderance of adenomas in the family. I am now investigating the family tree or pedigree of as many generations and members of families with adenomas as is possible or practicable; this study represents only an incomplete survey as the remaining members of these families have thus far resisted sigmoidoscopic examination. Thus far single adenomas have been encountered in three generations of one family.

Cancer Potential

The question of transition from adenoma to carcinoma has been studied in various ways. Some fourteen years ago,[19] I observed adenomatous tissue in adenocarcinomas in 16 out of 150 consecutive colorectal surgical specimens, suggesting that cancer in these 16 cases had arisen in benign adenomas. The incidence of transition of adenoma to cancer was presumed to be even higher because of the known fact that the progression of a malignant process may destroy the original architecture of an adenoma beyond microscopic recognition. Furthermore, 37 of these 150 surgical specimens revealed concomitant polyps varying in number from one to five; almost all of these were less than 0.5 cm. in diameter. A more recent, as yet incomplete, study shows a higher incidence.

The inexperienced clinician is understandably confused because, at one extreme, there is the conjecture that "all polyps of the colon are cancers (carcinomas) or will become cancers if they are not destroyed and if the patient lives long enough,"[20] and at the other extreme is the belief that rectal adenomas are either malignant initially or tend to become malignant very early and that they do not become malignant over the course of time.[21] This belief was based on a 5- to 11-year follow-up study of 113 patients who had refused to have their adenomas removed; this group of patients was compared with 117 individuals whose adenomas had been extirpated. A more recent study[13] showed no conclusive direct evidence that benign adenomas undergo transition to cancer. However, the same authors[13] have found that cancer of the colon and rectum occurs "with 5 times greater frequency in polyp patients than in normal individuals," and "that patients with multiple polyps are twice as likely to develop carcinomas as individuals with a single polyp." I have observed the occurrence of cancer in the site of benign adenomas in 4 patients after a lapse of about three to four years. Interestingly, the sister of the fourth patient has harbored an adenoma for over 12 years, and it has remained benign. I have under observation 4 additional patients who have been known to have benign adenomas

for over 10 months, and 13 others with benign adenomas of from 2 to 7 years' duration who have thus far declined treatment (including one with a villous adenoma). These considerations have led me[22] to the belief that, while colorectal adenomas have a dangerous propensity to undergo malignant transformation, some may remain benign. However, since there are no gross or microscopic criteria that will enable the proctologic surgeon or the pathologist to predict a benign course for a given adenoma, nor when malignant transformation might be expected, I extirpate all colorectal adenomas upon recognition as a matter of good prophylaxis even if only a minority of colorectal adenomas do become cancers.

Distribution and Diagnosis

Clinically, the distribution of adenomas has been studied primarily by means of endoscopy and radiography. At present, the endoscope is by far the most reliable diagnostic tool. In a collective series of over 400 adenomas, over 90 per cent of the lesions were visualized with a 25 cm.-long endoscope; a 30 cm. scope was used on rare occasions. Seven per cent of the remaining proved polyps were located in the sigmoid colon. This lopsided 9 to 1 ratio suggests that a large number of small adenomas situated above the reach of the sigmoidoscope must have escaped detection. It should be stressed that the present-day radiographic techniques that are utilized for the detection of polyps that are situated above the reach of the sigmoidoscope usually fail to detect adenomas smaller than 0.5 cm. in diameter, whereas endoscopy invariably detects adenomas smaller than 2 mm. in size. Hence, the exact incidence of adenomas above the reach of the sigmoidoscope cannot be established with precision at this time.

Special radiographic techniques are now in the process of perfection. The differentiation of fictitious from true polyps is particularly difficult. A knowledge of the radiographic limitations and a close cooperation between the roentgenologist and clinician are very essential.

Classification

Current knowledge does not justify a complex classification nor is one desirable as it tends toward confusion. Recently an attempt has been made to discard the grossly descriptive term "villous" and to substitute for it the microscopically descriptive term "papillary." Unfortunately, papillary adenomas are readily confused with anal papillae which are benign fibroepithelial polyps. Nor does the term "papillomatous" appear to be an improvement. Gross descriptive terms have effective teaching value. A classification of adenomas into (1) single or multiple (scattered); (2) smooth or villous; (3) pedunculate or sessile; and (4) benign or malignant is simple and logical. Malignancy in adenomas is best described as noninvasive or invasive; these terms have vivid meanings to all clinicians.

Pathology

Reports of adenomas of the large bowel should state the definitions and criteria of histological examination so that the basis for diagnosis may be clear. The proctologist and the pathologist must work in close liaison and use the same terminology. It is not an oversimplification to consider an adenoma as a pedunculate or sessile glandular structure showing proliferation of intestinal epithelium without invasion of the muscularis mucosae, lymph channels, or blood vessels. The diagnosis of malignancy is made only on evidence of actual invasion by malignant cells through the *basement membrane or muscularis mucosae* and not simply on the penetration of the base of the adenoma. A complete discussion of this phase is given elsewhere.[23]

Treatment

For therapeutic considerations adenomas are divided into those situated within and those located above the reach of the sigmoidoscope.[23]

ADENOMAS WITHIN REACH OF SIGMOIDOSCOPE

Benign Neoplasms

Mucosal Excrescences—Mucosal excrescences and tiny sessile or pedunculate adenomas are extirpated *in toto* at the base with the cold, angulated biopsy forceps; the base is dessiccated with a ball-tipped electrode, and the specimen is submitted for histopathologic examination. At times, after preliminary biopsy, the remainder of the lesion is destroyed electrothermically either by means of a ball-tipped electrode or a curved alligator forceps. Diathermic destruction of any mucosal elevation of the large bowel

without preliminary biopsy is unwise. Some of the rectosigmoidal mucosal elevations that are only 2 to 3 mm. in diameter have proved to be adenocarcinomas, benign and malignant carcinoids, leiomyoma, and lipoma, as illustrated in the exhibit.

Pedunculate Adenomas—These lesions are removed at the base by means of a high-frequency snare. Adenomas that are situated below the peritoneal reflection are usually treated in the office, while those located above the peritoneal reflection, the mobile portion of the terminal bowel, are treated in the hospital. When looping of the pedicle is technically difficult or unsafe, the adenoma may be removed by means of a clamp and specially designed scissors.[23]

Sessile Adenomas—Small or medium-sized sessile adenomas located on the posterior and lateral walls of the rectum may also be successfully extirpated by means of the electric snare. Large sessile adenomas that are located below the peritoneal reflection are removed by means of the electric double-loop resector. Adenomas situated in the more inaccessible areas, such as the upper surface of a rectal valve, are extirpated with relative ease by use of the resector, although in these situations both the adenoma and the rectal valve have to be excised in some cases. Most of the tissue thus resected retains enough of the original architecture for adequate histopathologic examination.

Fractional and serial coagulation of adenomas, especially the sessile type, is unwise as malignancy within the depth or near the base of the polyp may be thereby overlooked for some time even by the experienced proctologist.

The detailed technique of the use of either the high-frequency snare or the double-loop resector has been described elsewhere.[24] It may be stated here that the safe use of either instrument requires considerable experience. The complications are also described elsewhere.[23] All the diagnostic and therapeutic instruments alluded to in this study have been designed by the author. They are manufactured by the American Cystoscope Makers, Inc.

Malignant Neoplasms

Noninvasive—Pedunculate adenomas with noninvasive foci of malignancy may be extirpated by means of the electrothermic snare with uneventful healing of the bases. Noninvasive malignant foci are seldom encountered in sessile adenomas; in my experience, sessile polyps are invariably either invasive cancers or totally benign at the time of the examination. When malignant foci are found in sessile adenomas, they are best treated by radical surgical resection rather than by electrothermia or local excision.

Invasive—"Invasive adenomas" are regarded as frank cancers and are accorded radical therapy consistent with the modern concepts of adequate cancer surgery.

ADENOMAS ABOVE REACH OF SIGMOIDOSCOPE

Before an operation is performed, the adenoma should be identified radiographically on two separate sets of films taken at different times to avoid an unnecessary operation for a mistaken diagnosis of fictitious polyps.

Pedunculate Adenomas — Polypectomy through a transabdominal colotomy is a safe and adequate operation for benign pedunculate adenomas (1) if the body and stalk are firm or impressionable but not if they are hard and indurated; (2) if the pedicle or stalk is narrow, long, soft, and freely movable at its base; and (3) if the subjacent mesentery is free from palpable lymph nodes. In the presence of induration of any part of the polyp or fixation at the base with or without palpable mesenteric lymph nodes, segmental colonic resection with the corresponding mesentery should be performed. Examination of frozen sections of an excised specimen is believed by many experienced pathologists to be unreliable unless most of the specimen is diffusely invaded by cancer; isolated malignant foci can seldom be detected with certainty by this diagnostic procedure as the best pathologists may be deceived in both directions. Infrequently, a benign appearing lesion in the frozen section may prove to be malignant in the paraffin section, and vice versa.

In recent years the routine resection of the polyp-bearing segment of the bowel has been advocated for the extirpation of all pedunculate adenomas situated above the reach of the sigmoidoscope. This procedure is advised because in a few cases regional lymph node metastases have been encountered in the absence of invasion of the pedicle. About seven sigmoid colons are unnecessarily resected to accomplish the proper operation for one cancer.[25] However, this op-

eration appears justified because in the hands of some surgeons, polypectomy through colotomy and segmental resection are comparable in magnitude and subject to practically the same complications. Although some authors consider this radical operation unnecessary for pedunculate adenomas, I believe that this surgical experiment should nevertheless be encouraged, provided the morbidity and mortality are not increased following the more radical operation.

Sessile Adenomas—These adenomas should be treated by segmental resection of the colon with a wide V-shaped area of the mesentery so as not to miss the golden opportunity for cure of a grossly undetected cancer. It is particularly important to treat villous adenomas of the colon by segmental resection.

PREOPERATIVE TREATMENT

The principles of preoperative preparation with respect to the oral employment of nonabsorable or sparsely absorable antibiotic and sulfonamide chemotherapy compounds are now almost universally accepted. As of the time this paper is written, my preference is for the employment of a combination of oxytetracycline (Terramycin) and neomycin for their intraluminal (local) and systemic effects.[26] Recent studies in which I have participated showed that 5,7 dichloro-8-hydroxyquinaldine, when used alone, is erratic against gram-negative microorganisms but is more effective against many gram-positive organisms, including enterococci and yeast-like organisms. This chemobiotic combined with neomycin gives a greater reduction of all mentioned organisms and potentiates the reduction of the gram-positive bacteria.[27] The addition of this compound to the broad-spectrum antibiotics, such as oxytetracycline, is also in the process of investigation; and the value of Mycostatin in combination with other antibiotics is under study.

FOLLOW-UP OBSERVATION

Periodic endoscopic and roentgenoscopic examinations should be made for the lifetime of all patients in whom adenomas have been removed in order to detect new or recurrent lesions at the earliest time.

PEDIATRIC ASPECTS

Adenomas in juvenile patients present a microscopic architecture similar to that of adenomas in the adult except for a greater amount of connective tissue stroma. The connective tissue cells in these polyps are larger and more plump, and there is generally a greater amount of inflammatory cell infiltration. It is believed by some authors that malignant transformation may take place in polyps of infants and children, but I have never seen it.[28] However, absence of proof in my experience is no proof of absence.

The treatment of adenomas in juvenile patients is essentially the same as that for benign adenomas in adults.

SUMMARY

Overt or occult bleeding via the rectum may be caused by systemic diseases, notably blood dyscrasias and vitamin deficiencies, and by certain disorders in any segment of the alimentary tract. Of the intestinal lesions, hemorrhoids are the most frequent cause of bleeding; cancer is the most important cause; and adenomas occupy an intermediary position. Hemorrhoids occur very often in association with benign or malignant neoplasms; hence the finding of piles or any other benign lesion should not be considered a conclusive cause of bleeding until a complete proctologic (as well as a general) survey has been completed. All patients with rectal bleeding, regardless of age, should be accorded a sigmoidoscopy (for a minimum distance of 25 cm.) and radiography. A comprehensive physical examination should routinely include a fecal test for occult blood and a sigmoidoscopy for at least 15 cm. from the anal verge. The technique of sigmoidoscopy is described; it does not require a proctologist. Endoscopy is every clinician's "business."

Attention is particularly called to the numerous undiagnosed cases of iron-deficiency anemia (with a blood volume deficit) that are caused by slow and chronic bleeding from either internal hemorrhoids or adenomas; some of these cases may masquerade as cardiac neurosis or as organic heart disease.

The pertinent aspects of hemorrhoids and adenomas have been discussed.

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25 East 83rd Street.

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WISCONSIN SOCIETY OF OBSTETRICS AND GYNECOLOGY FALL MEETING

Hotel Foesta, Sheboygan, Wisconsin, October 15

9:30 a.m. WELCOME ADDRESS—Dean D. Willson, M. D., president, with introduction of hosts for meeting.

9:45 a.m. CASE REPORT: "CARCINOMA OF THE CERVIX COMPLICATING PREGNANCY" —Charles E. Ward, M. D., Appleton

10:00 a.m. CASE REPORT: "SPONTANEOUS RUPTURE OF A GRAVID UTERUS"—Gerald G. Kring, M. D., Madison

10:15 a.m. CASE REPORT: "DISPROPORTION IN PREGNANT DIABETIC"—Walter O. Paulson, M. D., Eau Claire

10:30 a.m. PRESENTATION BY FACULTY OF OBSTETRICS AND GYNECOLOGY OF MARQUETTE UNIVERSITY SCHOOL OF MEDICINE

11:00 a.m. CASE REPORT: "LABOR OBSTRUCTED BY DYSGERMINOMA"—William C. Mussey, M. D., Madison

11:45 a.m. "PREMATURE LABOR: MANAGEMENT WITH LUTREXIN"—Joseph T. Majewski, M. D., Milwaukee

Recess for Lunch

1:30 p.m. DATA ON 1953–1954 SURVEY OF MATERNAL MORTALITY IN WISCONSIN—Thomas A. Leonard, M. D., Madison

2:15 p.m. "PROLONGED LABOR"—John H. Randell, M. D., Professor of Obstetrics and Gynecology and Head of Department, University of Iowa, Iowa City, Iowa

3:30 p.m. BUSINESS MEETING

Long-Term Aureomycin Administration in the Prevention of Rheumatic Fever*

By ARVIN B. WEINSTEIN, M. D., and CHESTER M. KURTZ, M. D.
Madison

THE protection of known rheumatic fever subjects from recurrence or recrudescence is one of the most important aspects in their long-term medical management. The relationship of an antecedent beta hemolytic streptococcal infection to the occurrence or exacerbation of rheumatic fever is now generally recognized.[1-3] Massell,[4] in reporting on the experience at the House of the Good Samaritan in Boston, pointed out that 50 per cent of known rheumatic fever patients will have a recrudescence following a streptococcal infection. Rammelkamp *et al.*[5] have suggested that approximately forty per cent of streptococcal infections are either asymptomatic or so mild that medical care is not sought. Prophylaxis is preferable, therefore, to attempts to treat streptococcal respiratory infections once they occur.

The value of long-term daily sulfonamide administration as a prophylactic measure has been proved.[6-10] In the last few years the merit of a long-acting intramuscular penicillin preparation, benzathine penicillin, has also been established. [11-14] Daily oral administration of benzathine penicillin is equally effective.[15] Our experience with sulfonamides and benzathine penicillin confirms the observations of others. The occurrence of sensitivity either to sulfonamides or penicillin or, in a few instances, to both, among the children participating in our rheumatic fever program aroused our interest in Aureomycin (chlortetracycline) as a long-term prophylactic agent in rheumatic fever.

Methods

Twenty-eight patients from a rheumatic fever convalescent home (Kiddie Camp Rest Home) and the rheumatic fever clinics of the University Hospitals and St. Mary's Hospital, Madison, Wisconsin, form the basis of this study. They are the children who have participated in a long-term Aureomycin prophylaxis project who have had adequate follow-up studies. Observation and treatment of most of the children were begun at the convalescent home and followed in the clinics after the children were discharged from the convalescent home. The ages of the children ranged from 5 to 14 years.

Approximately ten milligrams of Aureomycin per kilogram was given each day in a single dose after breakfast. A multiple vitamin capsule supplying the average minimal daily requirements of vitamins A, C, D, and the B complex was also taken daily.

During the period of observation in the convalescent home the children were examined twice weekly by members of the attending staff. Special attention was focused on the occurrence of fever, rashes, gastrointestinal symptoms, frequency of respiratory infections and exacerbations of rheumatic fever. Complete blood counts and sedimentation rates were done every two weeks, and throat cultures were taken once a month. On the day of discharge from the convalescent home the children were examined in the rheumatic fever clinic, where, in addition to the routine laboratory studies, an orthodiascopic examination of the heart was done and an electrocardiogram made. The patients were then seen on a regular schedule at the clinics, usually at one month, three months, six months, nine months, and one year following discharge. After the first year they were checked every 3 to 6 months. At each clinic visit they were examined for evidence of Aureomycin toxicity, occurrence of respiratory infections, and reactivation of the rheumatic process. A blood count, sedimentation rate, and throat culture were done on each visit; and an orthodiascopic examination was made every 3 to 6 months.

Results

A total of 28 patients were followed for from 5 to 35 months on Aureomycin prophylaxis. This follow-up covered a total of 652

From the Rheumatic Fever Clinic, University Hospitals; the Kiddie Camp Rest Home; and the St. Mary's Hospital Rheumatic Fever Clinic, Madison.

Case No.	Birth Date	Diagnosis	Period of Observation	Aureomycin Daily Dose—mg.	Initial Weight	Aureomycin—mg. per kg. Initial Dose	Final Weight	Aureomycin—mg. per kg. on Jan. 1, 1955, or End Observation Period	Total Months Aureomycin Prophylaxis	Positive Throat Cultures Hemolytic Streptococcus	Negative Throat Cultures	Recurrences, Rheumatic Fever	Remarks—Side Effects, Etc.
1	9/43	Congenital vs. rh. heart disease	2/21/52 to 10/23/52	250	23.4 kg.	10.7 mg./kg.	.....	Same	8 mo.	0	2	0	Prophylaxis discontinued when congenital etiology established
2	8/47	Rh. fever	2/5/52 to 1/1/55	200 to 250	19.1 kg.	10.5 mg./kg.	24.0 kg.	10.4 mg./kg.	35 mo.	0	8	0	Aureomycin prophylaxis continuing
3	5/42	Rh. fever	12/26/51 to 5/30/52	250	33.1 kg.	7.5 mg./kg.	35.0 kg.	7.1 mg./kg.	5 mo.	0	1	0	5/19/52—Respiratory infection. Aureomycin increased to 250 mg. q.i.d. 5/30/52—Rash on abdomen. Aureomycin discontinued by pediatrician
4	1/41	Rh. fever	6/17/52 to 1/1/55	400 to 500	38.6 kg.	10.4 mg./kg.	56.3 kg.	8.9 mg./kg.	30½ mo.	2X—9/53 & 11/54	7	0	E.N.T. exam negative. Not clinically ill on either occasion. Aureomycin prophylaxis still going
5	5/42	Rh. fever	2/19/52 to 11/1/54	350	35.9 kg.	9.7 mg./kg.	45.0 kg.	7.8 mg./kg.	32 mo.	0	10	0	Discontinued by family doctor—vague abdominal pains, questionable relationship to Aureomycin administration
6	10/41	Rh. fever	8/4/52 to 10/15/53	350	32.2 kg.	10.9 mg./kg.	33.0 kg.	10.6 mg./kg.	14 mo.	0	6	0	Aureomycin discontinued when patient moved away
7	12/46	Rh. fever	4/29/52 to 1/1/55	250	22.7 kg.	11.0 mg./kg.	27.7 kg.	9.0 mg./kg.	32 mo.	0	12	0	Aureomycin prophylaxis continuing
8	8/40	Rh. fever	8/31/52 to 6/10/54	500	50.9 kg.	9.8 mg./kg.	59.0 kg.	8.5 mg./kg.	21 mo.	0	9	0	Discontinued because of development of nausea, abdominal cramps, soft stools. Not improved 3 mo. after discontinuing Aureomycin. Impression: functional G.I. symptoms
9	5/41	Rh. fever, Sub. glomerular nephritis	6/12/52 to 1/1/55	300	26.8 kg.	11.2 mg./kg.	37.5 kg.	8.0 mg./kg.	31 mo.	0	9	0	Aureomycin prophylaxis continuing
10	8/42	Rh. fever	4/17/52 to 3/15/53	250	23.6 kg.	10.6 mg./kg.	26.6 kg.	9.4 mg./kg.	11 mo.	0	2	0	Discontinued on advice of family M.D.—"sleepy in school."
11	6/40	Rh. fever, Bronchiectasis	6/3/52 to 1/1/55	500	45.9 kg.	10.9 mg./kg.	64.5 kg.	7.8 mg./kg.	31 mo.	0	13	0	Aureomycin prophylaxis continuing
12	9/40	Rh. fever	7/22/52 to 1/1/54	300	27.7 kg.	10.8 mg./kg.	33.4 kg.	9.0 mg./kg.	17 mo.	0	8	0	No side effects. Switched to benzathine penicillin by I.M. injection because Aureomycin administration unreliable
13	3/44	Rh. fever	3/16/54 to 1/1/55	300	29.5 kg.	10.2 mg./kg.	40.2 kg.	7.5 mg./kg.	9½ mo.	0	2	0	Aureomycin prophylaxis continuing
14	8/40	Rh. fever	2/5/52 to 1/1/55	400 to 500	38.1 kg.	10.5 mg./kg.	62.7 kg.	8.0 mg./kg.	35 mo.	0	6	0	Aureomycin prophylaxis continuing
15	3/47	Rh. fever	2/12/52 to 8/14/54	200 to 300	20.9 kg.	9.6 mg./kg.	28.4 kg.	10.6 mg./kg.	30 mo.	0	16	0	Recurrent tonsillitis on Aureomycin. T & A 11/25/54

Case No.	Birth Date	Diagnosis	Period of Observation	Aureomycin Daily Dose—mg.	Initial Weight	Aureomycin—mg. per kg. Initial Dose	Final Weight	Aureomycin—mg. per kg. on Jan. 1, 1955, or End Observation Period	Total Months Aureomycin Prophylaxis	Positive Throat Cultures Hemolytic Streptococcus	Negative Throat Cultures	Recurrences, Rheumatic Fever	Remarks - Side Effects, Etc.
16	3/45	Rh. fever	3/15/52 to 1/1/55	250	24.0 kg.	10.4 mg./kg.	33.6 kg.	7.4 mg./kg.	33½ mo.	0	3	0	Aureomycin prophylaxis continuing
17	7/48	Rh. fever	6/12/52 to 12/13/52 1/22/53 to 2/16/53	200	18.1 kg.	11.0 mg./kg.	19.5 kg.	10.3 mg./kg.	7 mo.	0	3	0	Aureomycin stopped by family M.D. after T & A, 12/13/52. After resumed, 1/22/53, "sore mouth." Sulfa later gave hives
18	8/39	Rh. fever	12/17/53 to 1/1/55	500	53.0 kg.	9.4 mg./kg.	56.0 kg.	8.9 mg./kg.	12 mo.	0	3	0	Aureomycin prophylaxis continuing
19	12/46	Rh. fever	1/5/54 to 1/1/55	250	25.4 kg.	9.8 mg./kg.	28.0 kg.	8.9 mg./kg.	12 mo.	0	6	0	Aureomycin prophylaxis continuing
20	6/40	Rh. fever	7/6/54 to 1/1/55	500	59.0 kg.	8.5 mg./kg.	74.0 kg.	6.8 mg./kg.	6 mo.	0	4	0	Aureomycin prophylaxis continuing
21	9/47	Rh. fever	2/12/52 to 1/1/55	250	17.2 kg.	14.5 mg./kg.	31.8 kg.	7.9 mg./kg.	35 mo.	0	12	0	Aureomycin prophylaxis continuing
22	10/43	Rh. fever	7/1/52 to 1/1/55	250	25.4 kg.	9.8 mg./kg.	33.6 kg.	7.4 mg./kg.	30 mo.	0	12	0	Aureomycin prophylaxis continuing
23	4/41	Rh. fever	5/1/52 to 1/1/55	500	48.1 kg.	10.4 mg./kg.	50.0 kg.	10.0 mg./kg.	32 mo.	0	14	0	Aureomycin prophylaxis continuing
24	10/39	Rh. fever	6/3/52 to 1/1/55	500	47.0 kg.	10.6 mg./kg.	51.3 kg.	9.7 mg./kg.	31 mo.	0	13	0	Aureomycin prophylaxis continuing
25	2/43	Rh. fever, Acute glomerular nephritis	5/15/52 to 1/1/55	300	28.6 kg.	10.5 mg./kg.	35.0 kg.	8.6 mg./kg.	31½ mo.	0	11	0	Aureomycin prophylaxis continuing
26	1/42	Chorea	3/5/52 to 1/1/55	350	33.6 kg.	10.4 mg./kg.	45.4 kg.	7.7 mg./kg.	34 mo.	0	11	0	Aureomycin prophylaxis continuing
27	10/45	Rh. fever	2/21/52 to 11/24/53	200	15.4 kg.	13.0 mg./kg.	22.7 kg.	8.8 mg./kg.	21 mo.	0	8	0	Otitis media. 6/1/52, throat culture negative hemolytic streptococcus. Discontinued 11/24/53. Administration by parents unreliable
28	7/40	Rh. fever	8/12/52 to 1/1/55	300 to 500	30.9 kg.	9.7 mg./kg.	51.0 kg.	9.8 mg./kg.	29 mo.	0	10	0	Aureomycin prophylaxis continuing

patient months of daily Aureomycin administration. Six patients were followed from 5 to 12 months, six were followed from 12 to 24 months, and sixteen were followed from 24 to 35 months. There were no recurrences of active rheumatic fever in this group. Of the 223 throat cultures taken, 221 were negative and only 2 were positive for beta hemolytic streptococcus (Table 1). Both positive throat cultures were obtained on the same child and were not accompanied by any clinical evidence of pharyngitis or constitutional reaction.

The average daily dose of Aureomycin at the beginning of the period of observation was 10.4 mg. per kilogram of body weight; and since the total daily dose was frequently not modified with gain in weight during this period, the average dose at the end of the study was 8.7 mg. per kilogram.

Side effects led to the discontinuation of the drug in 4 cases. In patient 3 a rash developed on the abdomen after the dose of Aureomycin had been increased to 250 mg. four times daily for 10 days on the advice of the family physician for treatment of a

respiratory infection. It should be noted that no skin rash appeared while this patient was taking the single 250 mg. dose daily. Patient 8 had been on Aureomycin prophylaxis for 20 months when nausea, abdominal cramps, and soft stools developed. She was a very anxious and insecure girl with many neurotic traits. Her symptoms persisted even after she had been off Aureomycin for three months and finally subsided on antispasmodic and sedative therapy only to recur intermittently with periods of tension. In patient 10 the Aureomycin was stopped by the family doctor because the child became sleepy in school. Patient 17 had a tonsillectomy on Dec. 13, 1952, at which time Aureomycin was temporarily discontinued by the local doctor. After it was resumed on Jan. 22, 1953, a sore mouth developed and the drug again was discontinued. This child, at a later date, developed hives with sulfonamide administration. Careful analysis of these four cases raises the question as to whether the side effects noted can be traced directly to the single daily prophylactic dose of Aureomycin in any instance.

Patient 15 represents a possible failure of the protective effect of Aureomycin against repeated throat infections. This youngster had recurrent tonsillitis while taking Aureomycin and finally had tonsillectomy and adenoidectomy several months after the drug was discontinued. The throat cultures were never positive for beta hemolytic streptococcus. This case illustrates the inability of antibiotics in small doses to protect patients from recurrent tonsillitis if the tonsils are grossly diseased and the seat of chronic infection. In this regard it should be pointed out that, as a group, these children suffered from fewer respiratory infections than they had in previous years, and those infections that did occur tended to be milder and shorter lived.

Discussion

Since our study was initiated in late 1951 and early 1952, several papers have appeared on the use of Aureomycin in the treatment and prevention of beta hemolytic streptococcal infections. McVay and Sprunt[16] reported on 23 cases of rheumatic fever followed an average of nine months on Aureomycin prophylaxis with only one recurrence. Houser *et al.*[17] treated 1,009 patients with Aureomycin on three different schedules for exudative tonsillitis and pharyngitis, predominantly streptococcal in etiology. A control group of 1,035 patients received no treatment. Among the Aureomycin-treated group, the infecting type of organism persisted in 35 per cent of patients after cessation of treatment. At the end of the schedule I treatment (11 Gm. over six days), the carrier state was reduced 52 per cent over that in the untreated control group. On schedule II (10.5 Gm. over five days) the reduction in carrier state was 42.6 per cent, and on schedule III (8.0 Gm. over four days) the carrier state was reduced only 39.5 per cent over that in the control group. The authors point out that the length of treatment in all three schedules may have been too short and that the streptococci might have been more effectively eradicated on a longer treatment schedule. Rheumatic fever developed in 5 patients in the treated group and in 20 in the control group, representing a reduction in attack rate from 1.93 per cent in the controls to 0.5 per cent in the treated patients. The same authors[17] point out that penicillin is more effective in eliminating the infecting streptococcus in a similar treatment period since there is only a 12 per cent persistence of the same type of organism at the end of treatment.

The problem of a suitable dose of Aureomycin for long-term prophylaxis merits some consideration. Our plan was to maintain a dose of approximately 10 mg. per kilogram as a single daily dose. Whitlock and associates[18] found that single oral doses of Aureomycin of approximately 11 mg. per kilogram in 17 children gave serum levels of 0.55 micrograms per cc. at one hour, 1.21 at four hours, 1.17 at six hours, and 0.79 at eight hours. Ross[19] reported levels of 2.0 to 2.4 micrograms per cc. after one dose of Aureomycin of 10 mg. per kilogram of body weight, the peak usually being 4 to 6 hours after the oral administration. Doses of 5 mg. per kilogram of body weight gave levels only slightly lower at 4 hours—1.7 micrograms per cc. Our observations indicate the effectiveness of 8.7 to 10.4 mg. per kilogram in the prevention of streptococcal infections and the sequela of rheumatic fever. The excellent tolerance of patients for Aureomycin in these doses for long periods of time is noteworthy.

Summary and Conclusions

1. Twenty-eight known rheumatic fever subjects ranging in age from 5 to 14 years

received Aureomycin in an initial dose of approximately 10.4 mg. per kilogram for periods of 5 to 35 months.

2. The incidence of side effects was extremely low.

3. There were no recurrences of rheumatic fever in this group.

4. Of 223 throat cultures for beta hemolytic streptococcus, only two were positive.

(C. M. K.) 1901 Monroe Street.

We are indebted to Dr. Stanton Hardy, Lederle Laboratories Division, American Cyanamid Company, New York, New York, for the Aureomycin used in this study.

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AMERICAN COLLEGE OF PHYSICIANS MEETING

The Midwestern Regional Meeting of the American College of Physicians will be held at the Memorial Union theater, University of Wisconsin, Madison, on Saturday, October 15. Wisconsin internists are well represented among the authors of the many papers to be presented, which touch on almost every aspect of internal medicine.

Any Wisconsin physician who wishes to attend will be welcome. There is no charge for registration.

HEALTH FILMS

Nearly 400 titles of sound movies, sound and silent filmstrips, and transcriptions on health are included in the 1955 edition of *Health Films*. Subjects include mental health, nutrition, dental care, heart disease, cancer, sex education, home safety, and others.

All of these aids may be borrowed by residents of Wisconsin without charge from the Film Library, State Board of Health, Madison 2.

The First Medical Faculty of the University of Wisconsin

Part II (Conclusion)

By W. S. MIDDLETON, M. D.
Washington, D. C.

Fig. 2—Dr. Ezra S. Carr

THE appointment of Ezra Slocum Carr to the professorship of chemistry and natural philosophy brought one of the most colorful figures in contemporary academic life to the campus of the University of Wisconsin (1856). In 1853 the Regents had elected him to the same chair. In a letter to Chancellor Lathrop, Carr declined with regret, "It would have gratified me had the income of the chair . . . been sufficient to enable me to remove at once to Madison." In a communication to the Regents, Lathrop stated, "It is quite obvious that this maximum salary of a Professor in our University, $1,000 per annum, will not secure to the chair the desired usefulness and distinction." While no mention is made of the salary, the Report of the Regents contains this note: "Ezra S. Carr, M. D. Inaugurated January 16, 1856. The Faculty is now full." There were six professors for 148 students!

Doctor Carr delivered "An Inaugural Address" before the Regents in the Senate Chamber of the Capitol, January 16, 1856. Much of his discourse is platitudinous by modern standards. He made an eloquent appeal for the support of natural science. Realistically, he despaired of the monetary assistance of alumni. "Enthusiasm faints in the appeal to the pocket, and the stubborn fact remains that Alma Mater's grandchidren *(sic)* hurry without her blessings to the cars and the counting room." He did not lack a practical eye, as witness two quotations: "Let our educational system be constructed in accordance with our national ideas, let their utility and economic value be fully demonstrated, and our institutions will speedily become intellectual hearts, whose systole and diastole would alike vitalize and invigorate the whole body politic." "Let the experiment be fairly tried, and we shall have no need of 'People's Colleges' and 'Industrial Schools,' unnaturally disconnected from other parts of the educational system, and trammeled by private interests and relations. The University belongs to the state, make it what it should be, and an influence will go down from it through the colleges, the academies and schools, and abroad through the whole community, which will prove its value, and endear it to the heart of every citizen." Carr closed on a note of flattering prophecy: "Looking into this great west with an eastern eye, I have long thought it the destiny of Wisconsin, to become the educator in the galaxy of states."

Carr was born in Stephenstown, New York, on March 19, 1819. He graduated from Rensselaer Polytechnic School, Troy, and was immediately engaged in the geological survey of New York. In this capacity he was able to begin his medical studies at Albany Medical College. He transferred to Castleton Medical College, Vermont, and received his doctoral degree in 1842.

Peripateticism was common in the academic life of the mid-nineteenth century in America. Carr's career of teaching was ini-

tiated by his appointment as professor of chemistry and natural history at Castleton, where he remained for 12 years (until 1854). Between 1846 and 1850 he commuted between Castleton and Philadelphia, where he is reported to have lectured in the Philadelphia Medical College. The identity of this post has not been disclosed upon careful study. In 1853 he returned to the University of Albany as professor of chemistry, from whence he was attracted by the opportunities in Wisconsin (1856). Two further appointments must be reconciled. He was acting professor of natural history at Middlebury College (1853–1854). In addition he served as chemist to the State Agricultural Society of New York.

The natural beauty of the campus of the University of Wisconsin was not lost on Doctor Carr. The physical plant of the University in 1856 was less impressive. North and South Halls had been completed. They served the dual functions of dormitories and classrooms. In South Hall, "One of the lecture rooms has been seated and furnished for the use of the Professor of Chemistry and Natural History." The Regents appropriated $1,200 to purchase a collection of fossils from Doctor Carr (1856). The following year (1857) their report notes. "The Cabinet has been greatly enlarged by the purchase of the valuable collection of Professor Carr made at Albany, etc. Containing full suits of New York fossils, it will afford means for the solution of questions which may arise in the prosecution of the geological survey of our State without the necessity of going abroad for the purposes of comparison and classification." After a detailed inventory in 1865, Carr concluded that except for a collection in Michigan it was the "finest collection in the Northwest." He placed a value of $15,000 upon the cabinet of specimens. The survey included all teaching paraphernalia. One microscope valued at $100 was listed! Contemporary opinion of the educational worthiness of collections of natural history items was widely divergent. A segment of the faculty spoke disparagingly of the "dusty specimens" and "moth-eaten" animals. Some dispute arose with the Regents regarding the possession of some elements of the collection. When they suggested a quitclaim of $25, Carr disdainfully rejected the offer.

Carr early described his pedagogical methods in the Report of the Regents (1856). The course would be offered to seniors only. "Instruction will be rendered in this department mainly by a regular series of lectures with intermediate examinations. The lectures will be attended by ample experiments and demonstrations illustrative of the general reasoning in each science. The course . . . will occupy one year . . . fall term, geology and mineralogy; winter term, chemistry; spring and summer term, Botany and Zoology, etc."

Professor George S. Bryan, in a scholarly review of the history of botany at the University of Wisconsin, cites Carr's failure to reflect the current trends of description and classification. An innovation, however, must have vastly impressed his students: "The instruction in this department is given by lectures and demonstrations on the part of the Professor . . . The recitation of the student consists in his giving a lecture, illustrated with experiments and demonstrations on the same subject and after the manner of the Professor." (Report of Regents, 1857)

In the Report of 1856 the Regents announced that "he (Prof. Carr) will lecture on Agricultural chemistry and the *applications of science* to the *useful arts*. This course of instruction is expressly designed for young farmers and artisans of the State." With the course's emphasis on the practical aspects of the subject, Professor Bryan was doubtless correct in considering it the nucleus or germ of the College of Agriculture. Cantankerous and frequently at odds with his fellow faculty members, Carr did not hesitate to take issue with the Regents as the following quotation indicates: "The importance of this will be better understood by recognizing the fact that these departments connect the University directly with the industrial interests of the State, by affording instruction to young men, in Agriculture, Mining, etc., and that in some eastern colleges whose announcements are not more formidable than our own *six* able professors are occupied in giving instruction in departments that are here performed with only *one*." In the present relation his nomination as professor of chemistry and pharmacy in the Medical Faculty links his name indelibly with this almost forgotten phase of Wisconsin medicine.

The pall of the Civil War stifled academic activity and growth. The youth exchanged the relative calm of the classroom for the turmoil and strife of the training camp and

battlefield. Women were welcomed to the University for the first time. Although Carr did not enter the military service, his services were repeatedly invoked. On one occasion the death of a soldier at Camp Randall after his taking a Dover's powder led to a court of inquiry. Doctor Carr assisted in the necropsy that established a natural cause of death.

The fourteenth meeting of the American Medical Association convened in Chicago on June 2, 1863. Two previous meetings had been cancelled because of the exigencies of the military situation. Under the subterfuge of attendance upon the National Canal Convention called for the same time, commutation of railroad fares was obtained for delegates of the American Medical Association. The meeting was divided between Bryan Hall and the Methodist Church Block. The delegates took official umbrage at the interdiction of calomel and antimony by the Surgeon General of the Army, who "had committed a most grievous offense against the dignity, usefulness and humanity of our profession; that he has heaped unmerited *insult* on intelligent, scientific and humane corps of army surgeons, that he has injured in a most serious manner, the regular profession. We regard the order as an unwarrantable assumption of authority and a reckless attempt to cut the Gordian knot of intricate pathology by the exercise of official power." Apparently the delegates were in a combative mood. They resolved to memorialize the military authorities on the lack of adequate rank for medical officers. The perennial problem of the relation of the medical staff to the line was discussed. Doctor Carr was elected a vice-president at this session.

He was much in demand as a popular lecturer on scientific topics. His regular lectures were at times attended by townsmen.

"Professor Carr's chemestry *(sic)* lectures at the University were not only attended by the students, but by citizens who take advantage of the instructive entertainment that they afford. We intend profiting from one of these lectures, and will give full information when and where they are held." (*Wisconsin State Journal*, March 3, 1864)

Mindful of his responsibilities as a citizen, Doctor Carr gave a series of lectures to the public. They were well noticed and reviewed in the current newspaper. The account in the *Wisconsin State Journal*, March 27, 1865, is especially illuminating:

"The 'Air we Breathe'—the lecture by Prof. Carr on Saturday evening, for the benefit of the Soldiers Aid Society, was well attended, as it deserved to be, for it was an instructive and exceedingly interesting lecture. Philosophical or chemical subjects are not always popular, being treated too often with technical skill, which is not commonly understood; Prof. Carr, however, who is well acquainted with the demands and tastes of popular assemblies, and who is happily skilled in adapting himself to them, never allows a dry theme to make *him* dry. His lecture abounded in very successful and brilliant experiments. It was such a lecture as always benefits an audience—far more profitable and indeed far more entertaining than the miscellaneous lectures which some cities import from abroad, manufactured to tickle a temporary taste. Few scientific lecturers are so thoroughly versed in their subject, and so impressive and eloquent in dealing with it as Prof. Carr. He speaks again this evening; subject, 'The water we drink'; also tomorrow evening; subject, 'The fuel we burn.' Our citizens have a rare opportunity thus afforded to listen to philosophical and practical instruction, and at the same time assist soldiers' families. We hope they will improve their opportunity."

A total of $200 accrued to the benefit of soldiers' families from this course of lectures by Doctor Carr. In a further extracurricular capacity he served as commissioner of the State Geological Survey of Wisconsin. But his skein at Wisconsin was running out. In the reorganization of the University after the war, Carr was not in sympathy with certain policies and resigned his chair in 1867.

From Wisconsin, Carr went to Rush Medical College as professor of chemistry. His tenure was short-lived. In 1868 he resigned; and the following year (1869) he was appointed professor of agriculture, chemistry, and horticulture at the University of California. In an expansive, prolix dissertation on "The Patrons of Husbandry on the Pacific Coast," Carr acknowledged his indebtedness to President John H. Lathrop for his thoughts on "The Office of Agriculture in the Social Economy." The subtitle, "Man and Nature" is reminiscent of a later distinguished figure in Wisconsin life. As Superintendent of Public Instruction in the University of California (from 1875), Carr addressed the California State Agricultural

Society at Sacramento, September 23, 1875, on "Child Culture." In this presentation he made the novel suggestion of a "National School of Pedagogy or Normal School" patterned after West Point and Annapolis.

A member of the American Association for the Advancement of Science from its foundation, Carr maintained an active interest in medical and other scientific advance. Among his friends was John Muir, who wrote, "I shall not forget the Doctor, who first laid before me the great book of Nature, and though I have taken so little from his hand, he has at least shown me where those mines of priceless knowledge lie and how to reach them."

Dr. D. C. Ayres

Dr. D. C. Ayres of Green Bay was named professor of obstetrics and diseases of women and children in the proposed faculty. Of his life only the salient details have been disclosed upon careful study. He was born in 1821. No record of his medical education has been encountered; but Ayres practiced in Green Bay until his enlistment with the Seventh Wisconsin Regiment in August, 1861. He saw continuous service until he was mustered out July 6, 1865.

Apparently Ayres' activity in the proceedings of the State Medical Society brought him to Castleman's attention, since he was president of this organization in 1857. His membership is recorded through 1878. He died on February 1, 1890, in Brooklyn, New York, while on a visit to his son who was an officer in the Regular Army.

Dr. G. D. Wilber

In that period galenical preparations held a prominent position in the treatment of disease. By the same token a knowledge of botany was deemed essential in the training of a physician. Courses in materia medica and botany were included in the curricula of all medical schools. To this combined chair in the faculty of the proposed Medical Department, Dr. George D. Wilber of Mineral Point was named.

George Densmore Wilber was born in Portland, Chautauqua County, New York, in 1828. He migrated to Elgin, Illinois, in 1843. He studied medicine and graduated from the Indiana Medical College of Indianapolis in 1848. Engaging in the affairs of organized medicine, Wilber served as the Secretary of the Wisconsin State Medical Society from 1850 to the Civil War. When the terror of Asiatic cholera struck Iowa County (1849–1850) he was not on the roll of honor of physicians who remained at their posts of duty. During the war he was surgeon to the Fifth Wisconsin Infantry Volunteers. Thereafter, apparently appreciating the inadequacy of his formal medical education, he took special courses at Bellevue Hospital Medical College and the Columbia University College of Physicians and Surgeons. At the same time he availed himself of the opportunity to attend the clinics in the metropolitan hospitals.

Wilber returned to Wisconsin, but his health failed and so he moved to Silverton, Colorado, in 1881. Still pursuing the will-o'-the-wisp, the ideal climate, he finally died of pneumonia in Pasadena, California, on December 11, 1897. The record leaves no written evidence of any contribution of Dr. George Wilber to the clinical or the educational advancement of medicine.

Dr. Joseph Hobbins

Joseph Hobbins was named professor of surgery in the Faculty of Medicine. From the standpoint of education and training he was probably the best qualified man of the group. Born December 28, 1816, in Wednesbury, Staffordshire, England, young Hobbins attended Colton Hall near Rugely. At 16 he was apprenticed to Doctor Underhill of Tipton. An Indenture of Apprenticeship was executed "for the consideration of £98/10, Sept. 3, the third year of the reign of William the Fourth, 1832." Pursuing his medical course at Queen's College Medical School, Birmingham, he graduated with honors in 1838. Thereupon he entered Guy's Hospital, London, and sat under such masters as Richard Bright, Sir Ashley Cooper, and Thomas Addison. He, moreover, attended clinics in Brussels, Paris, Dublin, and Edinburgh, which were enjoying their clinical heyday.

In 1840 Hobbins sailed for America. On shipboard he met Sarah Badger Jackson, who was returning from a European sojourn with her parents. There followed a singular period of indecision, frustration, and confusion. In the first place, Miss Jackson returned to England to marry Joseph Hobbins on October 11, 1841, in St. George's Church, Liverpool. The dreary Midlands oppressed

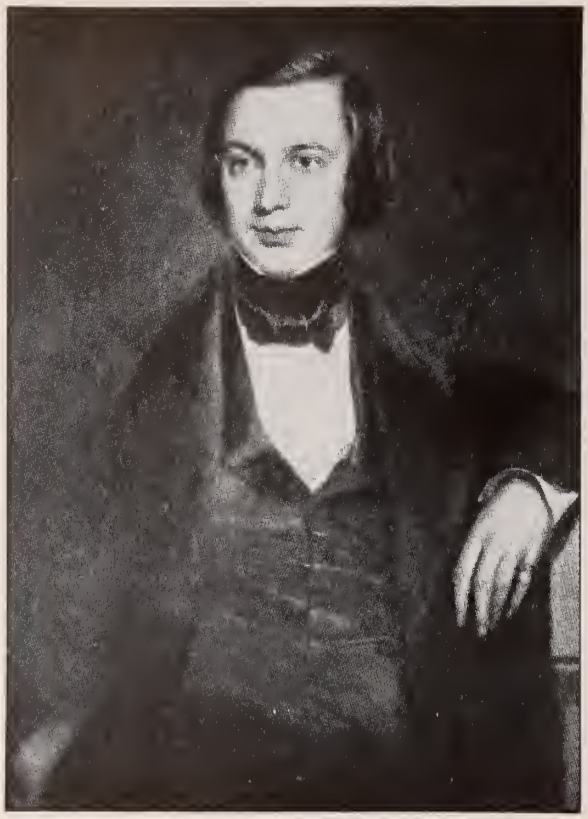

Fig. 3—Dr. Joseph Hobbins (1841)

the young Mrs. Hobbins in body and soul. Although Doctor Hobbins developed a thriving practice in Wednesbury, the couple determined to return to America and the doctor settled in practice in Brookline, Massachusetts, close to Mrs. Hobbins family at Nonantum. Joseph's brother, William, joined him in practice; but, unhappy, he returned to England in one year. After three years, Joseph's health began to fail. The death of their first-born child hastened the decision to return to Wednesbury. Better circumstances attended the reestablished practice; but an undercurrent of unrest may be detected in correspondence of that period. Again the death of a child (September, 1846) was a determining factor in the family reaction. Mrs. Hobbins wrote, "His death severed, as it were, in an instant all the ties, the fond hopes that I had thought would have bound me to England." Added to this circumstance came hard times in spite of a growing practice. Hobbins started an apothecary shop to help matters, whereupon Mrs. Hobbins wrote, "Yet how mingled with bitterness and grief are my feelings, for it is the seal set upon our remaining in England. The sacrifice of all my husband's ambitions and hopes. My heart is touched with sorrow for him, so talented, so fitted to occupy a more elevated position in life, he who has been so beloved and respected and who has moved in so different a sphere, doomed to a life in which I feel he is compelled by necessity, by misfortune; but unavailing are regrets or tears." The hegira from the Midlands was in full sway. Canada, Australia, New Zealand, and America beckoned with attractions, real and fancied. An epidemic of cholera distracted their further attention for a time. The Health of Towns Act gave Joseph Hobbins a mission in securing a pure water supply in the Black Country. An interesting recognition came to him in the form of an honorary degree from Columbia College (now George Washington University) in 1850.

Two reverses befell Hobbins in 1852. An attempt to sell his practice was unsuccessful. Then he failed the Edinburgh examinations. He wrote to his wife: "It is evidently no use my trying to get forward in this world with a *jump*. I was not born under the influence of the sign of Mercury—I must go steadily on. Well, perhaps it is best; I have too much ambition, and know not to where it would lead. But enough, let us be wise in the future and enjoy what we have rather than living for things which we never shall have. I am determined now to sit down and pick up my daily living like the greater and perhaps the wiser part of mankind, and who knows but what I may prosper the more."

A year's visit from Mrs. Hobbins' mother, Mrs. Kendrick, was apparently motivated by a desire to block emigration to Australia. Alluring prospectuses and advices from Wisconsin determined the second transplantation to America in 1854. After a shipwreck on Arclow Banks off the coast of Ireland and a trying passage to New York, they came to the Middle West by way of Albany, Dunkirk, Cleveland, Toledo, and Chicago. The limb from Chicago to Milwaukee was covered by boat. Thence the new railroad brought them to the end of the line in Stoughton. The last stage to Madison was accomplished in a springless, hard-seated wagon over muddy, rutted roads. The journey from New York had taken 12 days. Not until May, 1854, did the first train over the Milwaukee and Mississippi Railway draw into West Morris (Main) Street Station with

2,500 celebrants from Milwaukee together with the Milwaukee Fire Company.

The idyllic beauty of the Blooming Grove homesite overlooking Lake Monona and the city palled in the rigors of the Wisconsin seasons. The rough, muddy roads in the spring and summer and the blizzards in winter made the detachment from Madison and a growing practice serious handicaps. Water transport, too, was uncertain. After two and one-half years the Hobbinses bought a home on West Morris (Main) Street. The location was central in that period. Lake Monona was two blocks removed; and the heavily wooded Capitol Park, a favorite picnic spot, was four blocks away. Madison was then a quiet little city of some 4,000 inhabitants.

Joseph Hobbins rose steadily to the peak of his profession in Wisconsin. He brought to the community not only his personal capacities as a physician and surgeon but membership in the Royal College of Surgeons (London), the Society of Apothecaries (London), and the South Staffordshire Medical Society, and fellowship in the Massachusetts Medical Society. His interest in organized medicine found him active in the Dane County Medical Society, the Central Wisconsin Medical Society (president, 1885), and the State Medical Society of Wisconsin. Since the establishment of the Medical Department was under serious consideration, it was but natural that a man of Hobbins' professional background should be consulted in the matter. The suggestion that Chancellor Lathrop entrusted him with the responsibility for the organization of the proposed department is gratuitous, since he had been in Madison only a year. Furthermore, Alfred L. Castleman had been actively associated with the movement for more than five years. Be that as it may, Joseph Hobbins was nominated as professor of surgery. No record of his further participation in the venture is encountered.

Bringing from his Staffordshire phase a high sense of civic responsibility, Hobbins served on the Common Council of Madison. In this capacity he was the father of the first Board of Health in Madison. On occasion his force was asserted in the control of such epidemic diseases as variola. Upon his urgent advice the Council bought two lots at the corner of Gorham and Patterson streets extending to Lake Mendota, as a hospital site. His vision was not consummated; and

Fig. 4—Dr. Joseph Hobbins (1890)

in 1890 the Council sold the plat for $6,000, which was expended for a stone quarry and a steam roller.

Doctor Hobbins was a staunch Unionist, but he did not join the Army. Instead, he lent every effort to improve the care of the Confederate prisoners confined at Camp Randall. It is assumed that he served in the capacity of a contract surgeon. After the war he was appointed an examining surgeon for the Pension Bureau.

In person Hobbins was fair and blue-eyed. Urbane, he possessed "intelligence and refinement, poise and culture, a countenance at once modest, romantic and poetic," according to contemporary account. His fine baritone voice, accompanied by his wife at the piano, found a pleasant expression in old English ballads, of which he was very fond.

Among Doctor Hobbins' avocations were horticulture and literature. He found particular interest in viniculture. In this pursuit the daughter, Josephine, was his constant companion. Her devotion is memorialized in the 1868 Report of the Wisconsin State Horticultural Society: "The Josephine is a hardy, strong, vigorous grower, and good bearer of good fruit, berry and branch fair size. . . This is a seedling, raised by myself, and I

am propagating it from cuttings. . . there is none like it." Hobbins served as secretary and president of the Madison Horticultural Society and was for five years president of the Wisconsin State Horticultural Society.

Particularly conspicuous was Hobbins' stimulation of literary activity in Madison. In October, 1877, he founded the Madison Literary Club, which has had such a profound influence upon the cultural life of the community. Indeed, without exaggeration it may be stated that not only its initiation but its very existence depended upon his exertions. He was its president from the foundation (1877) until his death (1894) with the exception of one year (1881). His home was the rallying point of a notable group of contemporary Madisonians and distinguished visitors. His second wife, Mary McLane of Baltimore, maintained the tradition of hospitality in the new home on Wisconsin Avenue. Josephine Hobbins married Dr. James Jackson of Stoughton, and he shortly moved to Madison to join Doctor Hobbins in the practice of medicine.

On its tenth anniversary the Madison Literary Club unveiled a portrait of Doctor Hobbins by James R. Stuart. In bespeaking the propriety of its hanging in the State Historical Society, Professor Charles N. Gregory characterized it "as the enduring memorial of a good man and a good life." In calm and equanimity, Doctor Hobbins lived to a ripe age, respected by his professional brethren and beloved by a host of kindred spirits in the circles he had enriched by his warm leadership. His passing (1894) was marked by general mourning and sincere encomium.

Dr. Alexander Schue

Alexander Schue, professor of institutes of medicine and pathology, affords an interesting study in psychology. In Germany he had had a sound general education. His interest in chemistry brought him under the master, Justus von Liebig. The political turmoil of the forties led him to seek refuge in the United States. Matriculating in the Medical Department at Transylvania University, he assisted Dr. Robert Peter in chemistry. Schue received his degree in medicine about 1850.

Shelbyville, Kentucky, was his first location in practice. Early success gave him promise of sustained growth. Moreover, his talents in chemistry found an outlet in teaching at Shelby College. Political unrest was abroad in the land. The Know-Nothings, apprised of the fact that Schue had neglected to take out his papers for citizenship, made him a target for their attack. Eventually, their opposition drove him from practice in the community (1855).

The refuge that Wisconsin had afforded his fellow countrymen presumably determined his movement to this state. A correspondence with Dr. Robert Peter gives an unusual insight into the newcomer's reaction to the Madison and the medical profession of that period.

In the first letter from Schue to Doctor Peter from Madison, October 1, 1855, he related the rigors of his journey from Louisville. He had called upon Lyman C. Draper and "found a remarkably affable and well-bred gentleman in him." In spite of the primitive order and high cost of living in the young state, the prospect was good. "I lost a good deal on my accounts in Shelbyville (mostly on rich people who jewed me down more or less and finally paid me in bad notes). I think, however, if I can sustain myself but a year or two here that my fortune is made."

His communication of December 8, 1855, is especially significant in his reference to the proposed Medical Department and the quality of its faculty. "Of our society I can say but little, except that it is in a primitive condition like in all new and rapidly growing places. Although a considerable of our community enjoy or have enjoyed the privileges of a refined life, yet everybody seems so intently bent on the pursuit of his own fortune that people have very little else to spare for each other save such advances and civilities as their mutually dependent condition demands.

"My business prospects are satisfactory, the amount of my income of last month being equal to the average amount of the proceeds of my practice in Shelbyville. This I think is doing well enough for the first month. But the superior advantage here lies in the kind of practice that falls into my hands. I have already performed two or three important surgical operations (last Sunday for Example I operated 2 strangulated Hernia—Pat. doing well—this the 7th day) and have now several important and exceedingly interesting cases on hand. Of one thing though I must complain and justly; that is: the lack

of courtesy and attention among members of the Profession. I know as yet only one Physician here (except by sight) who was courteous enough to call on me. The cause of this rude treatment in the profession lies in the mixed character of its members and the comparatively low estimate in which society holds them; which gives equal standing to the quack and charlatan, so the Homoeopathist and Hydropathist with the scientific and phylosophic physician. The population here consisting largely of Yankees who are acceptable to all isms accounts for this fact, deplorable as it is. Nor do I think that the Medical Department of the University, which is to be organized shortly (January 1, 1856) will exert a decided influence upon this state of affairs, most of the Professors thus far appointed being men of small merits and no reputation. Dr. Castleman—a native of Shelby County, Kentucky—who has appropriated the chair of theory and practice to himself is gone to Kentucky as I understand to get Professors for the 3 vacant chairs to wit: that of Anatomy, of Surgery, and Med. Jurisprudence. I understand that there are many applications for these chairs. This mode of pushing forward being contrary to my sense of propriety and decency I am of course 'out of the ring,' although I must confess that under other circumstances I would have liked to hold a chair, thus extending my influence and enhansing *(sic)* my position. However 'tempores mutantur.' "

The winter of 1855–1856 was a rigorous one according to Schue. (February 23, 1856, to Doctor Peter)—"We have had an unusually healthy season here, and on that account have been obliged to make extraordinary efforts towards supporting my family. Thus I have gone out 20 and 25 miles over the prairies in an open sleigh or on a wood wagon at a tempr of 16–18 bel. F. to see a single patient, and then have taken my pay in potatoes, pork or wood. But I have paid dear for the whistle, for besides freezing my nose and ears I have also frozen the points of nearly all my fingers so that I am at present not able to feel the pulse except with one or two fingers. The tempr has mostly ranged from 12–22 b– F. The lowest degree reached was –29. Provisions & wood have been enormously high and money scarce."

The medical affairs of the University of Wisconsin still occupied his attention. The same letter (February 23, 1856) to Doctor Peter was closed on a pessimistic note regarding the future of the University Medical Department. "It is not likely that the med. Dep. in our University will be organized this winter, perhaps never—the thing is too much mixed with politics. Efforts are made to defeat every scheme of Castelmans *(sic)* that he sets on foot. Castelm *(sic)* is here at present to 'belabor' the Legislature. I fear he will meet with slim success."

Schue's professional fortunes improved steadily. From a trying probationary period he appears to have been generally accepted, and his practice improved apace. On December 17, 1856, he wrote to Doctor Peter:

"I have entered a few months since into partnership with an American physician and have reason to look upon the result of that arrangement as entirely satisfactory. There is in general much good feeling manifest between the members of the profession here, fostered as it undoubtedly is through the agency of a medical society which was organized and called into existence by my efforts. Apropos! If you can favor us occasionally with some publications address them to the Dane Co. Med. Society. Our club is small but actuated by the right spirit."

In the same communication (December 17, 1856) Schue announced his appointment to the proposed Medical School. "I believe I never wrote you that I had been appointed to the chair of the Institutes of Medicine in the Medical Department of the State University. Although the faculty is fully organized, we have as yet made no arrangements for entering upon our duties, and it is not likely that we shall begin our lectures this winter. We are waiting for the Legislature, which convenes in January, to give us a sufficient appropriation to make the Department independent from the Balance of the University. Perhaps that we open in the spring. The winter here seems to me an inauspicious time for lectures in many respects. We shall never have any Southern students here. The climate is too vigorous—the tempr for the last week has ranged from — 10° to + 10°."

Schue's enthusiasm in the new prospect of teaching is reflected in a letter of February 7, 1857, to his mentor, Doctor Peter. "We shall not begin operations before next year. In a week or two I shall take the liberty of forwarding to you a number of circulars concerning the Med. Dept. of our Univ. for distribution among your students. We are bound to take the palm off of your southern

Colleges sooner or later, because we can afford to offer the tuition entirely *free*. We have determined upon a spring session both for the reason that we do not wish to interfere with your winter sessions and because the weather is so much more desirable."

The promised prospectus of the Medical Department has eluded students of this phase of the history of the University of Wisconsin. Such material would be invaluable in establishing the vision and the plans of approach of the physicians who were designed to pioneer in medical education in Wisconsin.

At this time (February 7, 1857) Schue indicated a concern for his health. "The severity of the winter and the consequent wear and tear of my constitution have induced me to give up my private practice and to accept of the Med. Superintendence of a private Hospital, which was originally constructed for a hydropathic Institution but is now a regular Hospital. Enclosed I send you one of my circulars. The place is perfectly enchanting, my position an exceedingly pleasant one, and my salary about $1000 better than the proceeds of my former practice. This together with my salary from the state will place me in a few years above those interminable trials and pecuniary vexations, which I have been subject to all my life."

An accompanying folder gave a glowing account of Lake Side Retreat, "delightfully situated on the South margin of Lake Menona, opposite and in full view of the City of Madison, and sufficiently removed from the Public Thoroughfare and Business Localities, to insure undisturbed quiet to the invalid. The Grounds, comprising about 50 acres, are beautiful and undulating, bordering the Lake for more than half a mile, covered with fine native oaks and shrubbery, and the scenery in the vicinity, embracing every variety of Landscape, makes the most enchanting and lovely retreat in the North-West."

Alexander Schue was not destined to enjoy the fruits of his planning and labors. Only 36 years old, he died October 8, 1857. The Daily State Journal for October 9, 1857, opened its editorial column for the following obituary:

DEATH OF DOCTOR SCHUE

"We announce with deep sorrow the death of A. Schue, M. D., who died at his residence in this city, yesterday afternoon, at 4 o'clock. Dr. S. had been a resident of this city about a year and a half, during which time he formed many acquaintances who will deeply mourn his death. He was a ripe scholar, a thoroughly read physician, a successful practitioner, and a gentleman in all his intercourse with his fellow men. For a time he had charge of the Water-Cure at this place, in which position he gave eminent satisfaction. He was highly esteemed by the members of his profession in this place, and they will deeply sympathize with his friends, in their irreparable loss. He was German by birth, but had been several years in this country.

"In the death of Dr. Schue, who was just in the prime of life and usefulness, the city has lost a valuable member of society, and the profession of medicine, an esteemed and scientific brother, who was an honor to his calling. Such a loss will be deeply felt in this community.

"The funeral will take place at the late residence of Dr. Schue, tomorrow forenoon at 10 o'clock.

"The Wisconsin Central Medical Association convened at the call of the President, for the purpose of making arrangements for attending the funeral of Dr. Schue, when it was

"Resolved, that we attend the funeral as a Society, and request the Physicians of the City and vicinity to join us in the procession.

"Also, a committee was appointed to prepare suitable resolutions commemorative of the deceased, to be presented at a subsequent meeting.

E. HEATH, *President*

C. B. CHAPMAN, *Sect'y pro tem.*"

The formal action and resolutions of the Central Wisconsin Medical Association on the death of Doctor Schue were published in the Daily State Journal, October 13, 1857. Impressive as are the tributes of his contemporaries, certain references to his personal affairs are particularly revealing. "His early investments proved unfortunate, from the effects of which he never fully survived; and yet though crippled he seldom and never lost his courage." President John Favill characterized Doctor Schue as follows:

"I do not say our friend was always right —that he was always just; but do say that I believe him to have been totally incapable of deliberate worng *(sic)*, or continued injustice. With his professional course since his identification with our Association you are all familiar. —The working element in the Doctor's nature was universally developed. You will hear me bear witness that he never shrank from an imposed burden and never failed. He was unassuming, always courteous, but self reliant. He was a delicate, sensitive, heart-felt, friend. His love for our Association was only surpassed by his love for his profession, to which he was almost a devotee; but he was called too soon for the realization of his hopes."

Particularly would Doctor Schue have appreciated the estimate of his fellow practitioners that was inscribed in the sentiment of one of the resolutions drawn by Doctors J. J. Brown, C. B. Chapman, and E. S. Carr:

"Resolved, That the death of Dr. Schue has removed from us a diligent, studious and consequently a valuable Physician and member of this association, and that we cannot regard this loss as confined to ourselves when we remember that in our late friend was happily combined the qualities of the good citizen as well as teacher and Physician."

The listing in the "Madison City Directory and Business Mirror" for 1858 leaves an unanswered question. Under Wisconsin State University at Madison there appears the following item:

"Faculty of Medicine.—Chancellor, John H. Lathrop, LL.D.; Dean (vacant by Dr. Schue's death.) Treasurer, A. L. Castleman, M. D.; Secretary, Geo. D. Wilber; Prof. Princ. and Prac. of Med., Alfred L. Castleman, M. D.; Prof. Chemistry and Pharmacy, Ezra S. Carr; Prof. of Surgery, Joseph Hobbins, M. D.; Prof. of Physiology and Path. Anatomy (vacant by Dr. Schue's death; Prof. Obstetrics, Dis'd Women and Children, D. Cooper Ayers, M. D.; Prof. Materia Medica and Botany, George D. Wilber, M. D.; Anatomy, Samuel W. Thayer, Jr., M. D.; Demonstrator of Anatomy, James M. Lewis, M. D."

Did Alexander Schue succeed Doctor Castleman in the deanship of this nebulous faculty? If so, is there some hidden source of information relative to his activities in this capacity?

The dramatis personae may make or break a play by their stage performance. The qualifications of the individual members of the first medical faculty of the University of Wisconsin may fairly be weighed by their personal capacities, training, and professional standing in the contemporary milieu. Unfortunately, the available information regarding two of these men, Doctors Thayer and Lewis, is entirely buried to the present reviewer. The sources concerning Doctors Ayres and Wilber are too inadequate to supply even contemporary judgment. Of the remaining faculty, there is a fair basis for an evaluation from the standpoint of personal and professional criteria. Doctor Castleman was undoubtedly the dynamic force behind the movement to establish the Medical Department of the University of Wisconsin at Madison a century ago. Ambitious and politically motivated, he lacked the persuasive capacity to weld the divergent forces of the period into a cohesive front. Furthermore, the administration of the University itself was passively, if not actively, resistant to the movement. The financial obstacle to its consummation was ever raised. Castleman eventually broke with the University authorities on the issue of the ultimate control of the Medical Department. His position that this element of the University should be operated by the medical profession as a separate educational entity was obviously untenable. The conclusion of his ulterior motives in a purely selfish interest is inescapable in the light of subsequent developments.

Of the remaining three faculty members whose biographical data are relatively comprehensive, Doctor Carr is the most picturesque. While he was a conspicuous figure on the University campus and in the life of the city, he apparently played a very inconsequential role in the attempt to establish the Medical Department. Perhaps his nomination was a conciliatory gesture to win University support. Whatever the covert explanation may have been, neither personal nor institutional enthusiasm was aroused. Only his name added prestige to a group that from the vantage point of years seems rather unprepossessing. Doctor Hobbins lent a splendid background of training and dignity to the group. While it is recorded that he advised with Chancellor Lathrop relative to the plans for the Medical Department, public notice of his active participation in the movement is singularly lacking. Yet from his subsequent leadership in the cultural life of Madison a very vital interest in medical education might have been anticipated. Castleman apparently was a lone wolf in this particular project, and it is possible that Hobbins' late appearance on the Wisconsin scene explains his minor role in this drama. Doctor Schue brought the continental tradition of basic training to Madison, although his medical education was obtained in this country. Of the entire group he alone had had teaching experience. It is conceivable that, having overcome his earlier prejudices, and with his training, Schue might well have proved the ablest teacher in the faculty.

Fate and the exigencies of the times ruled that medical education should not take its

roots in the University of Wisconsin 100 years ago. The First Medical Faculty was officially named by the Regents in 1855–1856. No record of their assemblage as a body is preserved. In the strict sense of the word they constituted a "paper" faculty. Isolated records of two grants ($450 and $500) for equipment by the Regents are encountered, but there is no comment as to their expenditure. Butterfield remarks, "The 'medical department' did not survive the last appropriation." Furthermore, this abortive effort had no influence upon the singularly slow evolution of the program of medical education in Wisconsin. For generations this state lost the flower of its youth in the field of medicine to adjoining and remote states where they sought professional training. In many instances as "intellectual hostages" they pursued their medical careers in these centers until the University of Wisconsin belatedly offered the complete medical course in 1925.

Material assistance in accumulating these data was lent by Charles H. Crownhart, Alice F. Jackson, Bettina Jackson, and Donald R. McNeil of Madison and George F. Lull of Chicago. Their courtesty is gratefully acknowledged.

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Circuit Programs

October
Tuesday, the 18th: Elks Club, Rice Lake
Wednesday, the 19th: Mead Hotel, Wisconsin Rapids
Thursday, the 20th: Elks Club, Appleton

CURRENT TREATMENT OF SYSTEMIC ARTERIAL HYPERTENSION: James W. Culbertson, M. D., Iowa City

SURGICAL EMERGENCIES IN CHILDREN: Kenneth Lemmer, M. D., Madison

ABORTIONS AND CHRONIC DISEASES RELATED TO OB: William C. Keettel, M. D., Iowa City

POISON CONTROL: Franklin J. Mellencamp, M. D., Milwaukee

CREDIT FOR A. A. G. P. MEMBERS: 5 hours of formal teaching credit for each meeting.

Cost: $6.00, including dinner and "coffee break" in middle of afternoon program.

To assist with proper meal planning, please send your reservation to the State Medical Society (Box 1109, Madison) immediately. Make your check payable to the State Medical Society of Wisconsin and indicate which clinic you will attend.

[OTHER CIRCUITS IN JANUARY *(Richland Center, Oconomowoc, and Sheboygan)* AND IN FEBRUARY *(Janesville, Stevens Point, and Green Bay)*]

THE MEDICAL FORUM

SMS BUILDING DEDICATION OCT. 15: AMA HEAD TO SPEAK

California Left-Wing Union, County Society Unite on Health Plan

Business Week Files Report

New York, Sept. 15.—Business Week reported in a recent issue that "a new trail in cooperation is being blazed by a working relationship established between a conservative county medical association and a left-wing union."

According to the article, entitled "Doctors, Union Fund Sign Up," the San Joaquin (Calif.) Medical Society is assisting in providing medical and surgical coverage for 550 longshoremen in the port of Stockton, Calif., and their families.

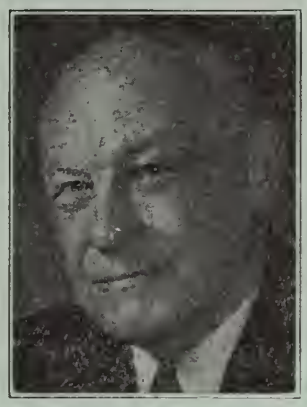
"The Stockton health contract," the article stated, "accords a degree of protection not commonly available in group coverage. But what makes it unique is that it bridges the chasm between closed-panel and open-panel health insurance.

"In California, that's an accomplishment: The California Medical Association has watched with disfavor the mushrooming growth of Henry J. Kaiser's closed-panel health plan, which now covers 500,000 on the coast. The CMA has its own open-panel plan, the California Physicians' Service."

The magazine also said:

"Although labor union speakers have often referred to the American Medical Association as the tightest closed shop-closed union in operation, it has never been a friendly description. The unions and A.M.A. have fought each other on broad questions of public policy such as a national health program and on local practical issues such as group medical coverage of union members."

Business Week said the union covered by the San Joaquin health insurance is Harry Bridges' International Longshoremen's and Warehousemen's Union.



DR. ELMER HESS
A.M.A. President

Dr. Middleton Stresses Full Care for Patients In VA Hospitals

Washington, Sept. 15.—Dr. William S. Middleton, chief medical director for the Veterans' Administration, said chronic patients unable to care for themselves would not be discharged from VA hospitals until arrangements for their care are completed "with their familiar, local agencies or other sources."

Dr. Middleton, former dean of the University of Wisconsin School of Medicine, was quoted in the Army Times Newsletter as saying he was attempting to repair damage done by efforts of VA hospital managers to increase patient turnover and reduce length of hospitalization wherever possible.

Dr. Middleton advised VA hospital managers that although he was in accord with efforts to boost turnover and reduce length of stays, "such factors must be subordinate to proper care and treatment of all patients, including those with chronic conditions."

DIGNITARIES OF STATE, NATION TO PARTICIPATE

Madison, Sept. 20.—Dr. Elmer Hess, Erie, Pa., president of the American Medical Association, Wisconsin Atty. Gen. Vernon Thomson and other top-ranking dignitaries will play leading roles in ceremonies marking dedication of the new State Medical Society of Wisconsin building here Oct. 15.

Dr. Hess and the attorney general will present appreciatory remarks on the occasion, as will Dr. Gunnar Gundersen, of La Crosse, chairman of the Board of Trustees of the A.M.A., and Dr. George F. Lull, Chicago, secretary of the A.M.A.

Presiding officer will be Dr. W. D. Stovall, Madison, past president of the State Medical Society. After invocation by the Rev. Fr. E. J. O'Donnell, S. J., of Milwaukee, president of Marquette University, Dr. Ervin L. Bernhart, Milwaukee, Society president, will make remarks fitting to the ceremony, as will Mrs. J. J. Boersma, Green Bay, president of the women's auxiliary of the Society.

Serving in escort capacities will be Dr. L. O. Simenstad, Osceola, president-elect of the Society; Dr. H. Kent Tenney, Madison, trustee of the Society Building Corp.; Dr. E. M. Dessloch, Prairie Du Chien, chairman of trustees, SMS Building Corp.; Dr. S. E. Gavin, Fond du Lac, chairman emeritus, Council of the Society, and Dr. N. A. Hill, Chicago, trustee of the SMS Building Corp.

Laying of the cornerstone for the new modern structure, a $385,000 project housing offices of the Society, the Blue Shield of Wisconsin and the Veterans' Service agency, will conclude initial dedication events.

A Council dinner for speakers, other dedication participants and invited guests will be held in the Society cafeteria, with Dr. R. G. Arveson, Frederic, council chair-

(Continued on page 440)

QUACKERY DISPLAY ATTRACTS STATE FAIR CROWDS

West Allis, Sept. 1.—Heavy daily registrations of visitors marked the State Medical Society of Wisconsin's display of quackery at the state fair Aug. 20–28.

John C. La Bissoniere, society field representative, estimated that more than 10,000 persons visited the exhibit in the Healthland corner of the Wisconsin At Work building. La Bissoniere had charge of the display and described it to guests.

The display featured a magic horsecollar (or theronoid); turtle oil (to live longer, like the tortoise); arthritis cure (also helps remove crustiness on eyelids); a drown radio therapeutic device to eminate radio waves through the body (destroying harmful bacteria, allegedly); a hair grower (consisting of an aluminum head bowl with a red Christmas tree bulb therein); a spectrochrome, using the principle of color waves as a cure-all, and several others, including uranium ore in a hot water bottle.

A sign, "Beware of the Quack," marked the center of the exhibit.

John C. La Bissoniere, field representative for the State Medical Society of Wisconsin, is shown (right) explaining some of the cure-all displays at the State Fair Aug. 20–28.

GIFTS BRIGHTEN SMS OFFICE

Madison, Sept. 15—Two gifts for the new State Medical Society building have gladdened the hearts of staff members. And it is expected Society members will have opportunities to use them often, too.

One put into immediate use was a portable electric coffee urn, capable of producing 48 cups, a present from W. E. Malzahn, an officer of the West Bend Aluminum Co. It occupies a prominent place in the cafeteria. Results were described as excellent.

The second gift was sent by F. S. Brandenburg, of the Democrat Printing Co., Madison. It is a Bushnell Spacemaster telescope, a standout attraction in the Council Room. The 'scope brings the capital city's skyline across Lake Monona almost within reach, or so it appears.

Almost unnecessary to state, the gifts are much appreciated.

Foundation Offers Financing Plan for New Physicians

Chicago, Sept. 22.—A helping hand to physicians in need of financial aid in establishing medical practice units was offered by the Sears–Roebuck Foundation, in cooperation with the American Medical Association.

Unsecured, low-cost, 10-year loans up to $25,000 will be available to physicians seeking to establish new practices but unable to arrange full local financing.

The plan requires that an applicant indicate a need for practice in the proposed locality, with good possibilities for success and public service and that he give evidence of effort and thought in planning a well-organized, effective practice unit.

The Foundation stated its plan is intended to "realize the principles of opportunity, incentive, mutual help and self-reliance; to give the American people the best possible medical care, and to help the American physician build for himself the most effective, rewarding and the most satisfying life as a professional man."

U. W. Graduate Takes Post with A. M. A. Research Group

Chicago, Sept. 15.—Dr. Norman De Nosaquo, a graduate of the University of Wisconsin School of Medicine in 1927, was named secretary of the A.M.A. Committee on Research. The post had been held by Dr. Paul L. Wermer, who resigned recently to join an eastern pharmaceutical concern.

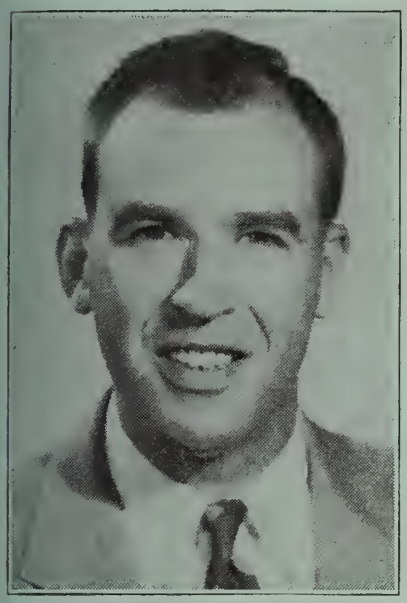
Dr. De Nosaquo recently completed 16 years service in the Division of Medicine of the Food and Drug Administration in Washington.

DEDICATION . . .

(Continued from page 439)

man, presiding. The main address, on the subject, "The Heart of Medicine," will be presented by Dr. Lowry H. McDaniel, Tyronza, Ark., chairman of the Section on General Practice of the A.M.A.

The new Society building is on the shores of Lake Monona, and replaces offices used since 1948 on Madison's near east side.



JOHN C. LaBISSONIERE

SOCIETY EMPLOYS NEW FIELD REPRESENTATIVE

Madison, Aug. 25. — The State Medical Society of Wisconsin has announced the appointment of John C. LaBissoniere, Milwaukee, as field representative.

LaBissoniere, 33, was brought to Madison after a year as district sales coordinator in Appleton for Wisconsin Physicians Service, the Blue Shield Plan of the Society. Previously, he had served for five years as a sales representative for Ayerst Laboratories of Milwaukee.

He graduated from Marquette University in 1947 with a Bachelor of Philosophy degree. During World War II, he served with the Marine Corps.

He has been a member of the Alonzo Cudworth Post, American Legion, and the North Shore Republican Club, both in Milwaukee.

Bulletin on Poisons Offered Through SMS

Madison, Sept. 20. — Physicians in agricultural areas where pesticides are in general use will be interested in the latest annual revision of "Clinical Memoranda on Economic Poisons."

This book is available without cost upon request to the State Medical Society office. It describes nearly 50 agricultural chemicals required in the production of foods and fibre crops and in the control of many disease-bearing insects. The booklet has been prepared by the U. S. Public Health Service after extensive research in the field and has been reproduced by the National Agricultural Chemicals Association.

In addition, physicians may obtain copies of an address by Assistant Surgeon General David E. Price entitled "Relationship of Pesticides to Health."

Grievance Guide to Be Set Up by AMA

State and county medical societies are asked to support a committee which seeks to develop a practical set of guides for grievance or mediation committees.

The House of Delegates approved a report from a special committee to recommend guides for grievance or mediation committees, which will include the organization and operation of such committees.

The committee's report to the House stated that "the importance of this study cannot be overemphasized since it is believed that a sound system of professional self-discipline is essential to medicine's public service."

The committee hopes to have a compilation of facts about grievance committees throughout the United States prior to the clinical meeting in Boston in December, 1955. The guide may not be completed, however, until 1956 or later.

JACK BURKE

NAME NEW PUBLIC INFORMATION AIDE

Madison, Sept. 1.—Jack Burke, 43, for more than 11 years a news and sports writer for The Associated Press in Madison, joined the staff of the State Medical Society of Wisconsin Aug. 22.

Burke, who resides only four blocks from the Society's new building on Lake Monona, will be a public information executive assistant. His duties will include writing the script for "The March of Medicine," regular weekly radio program featuring Dr. Robert C. Parkin.

A graduate of Wisconsin State College at La Crosse and the University of Wisconsin, Burke formerly taught and coached athletics at Lomira, Fort Atkinson and Cassville high schools.

INCREASE EXAM FEES FOR M.D.'S

Madison, Sept. 1.—Examination and reciprocity fees for doctors of medicine, physical therapists and chiropodists were increased by the passage of bill 415, A.

Requested by the State Board of Medical Examiners, the changes in the fees are expected to produce an increase of $4,000 annually in the Board's revenues.

The major changes which affect physicians are as follows:

1. **M.D. license by examination—$45 (now $40).**
2. **M.D. license by reciprocity—$100 minimum (now $75 minimum).**

Physical therapist certification by examination was increased to $25 from $15 and by reciprocity to $25 from $10. The chiropody certification by examination was set at $25. This is an increase from $20.

8 MORE HOSPITAL PROJECTS OKAYED

Washington, D. C., Sept. 15.—Wisconsin has eight hospital building projects approved but not yet under construction, according to the Washington Office of the American Medical Association.

Dr. Frank E. Wilson, director of the office, reports that the eight projects will cost a total of $3,181,315, including federal contributions of $1,140,826. The eight projects are designed to supply 240 additional beds.

URGE DOCTORS TO STUDY GUIDE ON UNION HEALTH CENTERS

"Guiding Principles for Evaluating Management and Union Health Centers" have been developed by the Council on Medical Service and the Council on Industrial Health of the American Medical Association.

The guide comes as a result of both councils' activities in following the development of various types of centers designed to provide medical services of a non-occupational nature to employees and union members. Conferences were held with representatives of medical societies where such centers are in operation and with the medical directors of those centers.

One of the big question marks always arising has been "what should be the relationship between the private physicians, the medical societies, and these centers?" This question always has arisen despite the fact that examples of union and management centers have existed for many years and despite the fact that most centers utilize the part-time services of private physicians rather than a full-time salaried medical staff.

The guiding principles were prepared to help local physicians answer their questions about such health centers.

The House of Delegates urged all local medical societies to obtain and study these guiding principles so that their opinions regarding the principles can find expression at the clinical session in Boston in December, 1955, when the guide will be submitted for approval.

A copy of the guide may be obtained by writing to the State Medical Society office, Box 1109, Madison, Wisconsin.

Listen to the "March of Medicine" on any one of 40 Wisconsin radio stations every week.

* * *

Remember—You are welcome to visit the new State Medical Society of Wisconsin building in Madison any time!

* * *

Have you sent your contribution to the Society's Charitable, Educational and Scientific Foundation Inc.?

* * *

A map showing the location of the S.M.S. building and other health and medical spots in Madison is available. Just drop a request to the S.M.S. and one will be sent to you promptly.

Two California Unions Praise MDs Ethics Policing Activity

Madison, Sept. 15.—Doctors and Teamsters' Union members of Northern California are pictured working hand in hand in a recent issue of the "Northern California Teamster," an official publication of two joint councils of the International Brotherhood of Teamsters which is affiliated with the A. F. of L.

In a special section of the newspaper, a dozen articles are used to show how "Doctor's Self-Policing Program" aids teamster members.

Teamster general president Dave Beck is quoted as favoring voluntary plans for medical care. Editorials congratulated the doctors of the Alameda and Contra Costa County Medical Society for their courageous action in insisting that high ethical standards be maintained.

"It is not easy to turn a critical eye on yourself and admit that all is not what you would like it to be," the editorial stated. "The doctors in those two counties have not only looked at themselves, found there was room for improvement in some spots, but did something about it.

"It must be emphasized, however, that whatever unethical practices existed before the formation of the self-policing system in those counties were very small. The vast majority of doctors certainly merit the high reputation that is theirs.

"But the doctors in Alameda and Contra Costa counties deserve even more than the high respect that belongs to them as doctors. They deserve additional praise for keeping the name of an honorable profession unblemished and setting up rules and regulations to see that it remains so."

Accompanying the editorial were articles explaining how the doctors in the two counties have set up a self-policing organization to handle such matters as overcharges, fee splitting, needless surgery, and similar complaints.

Letters from physicians in the San Francisco Medical Society and the Kern County Medical Society at Bakersfield illustrate how they are handling similar programs.

ON THE SMS CALENDAR . . .

Here is the meeting schedule for the next six weeks:

OCTOBER

8–9—A.M.A. Legislative Conference, Chicago.

13–14—Conference on Physicians and Schools, Highland Park, Ill.

14—Executive Committee and Council, SMS–Madison.

14—Reception for Dr. Elmer Hess, SMS–Madison.

15—Commission on Prepaid Plans, SMS–Madison.

15—SMS Building Dedication and Banquet.

16–19—Indiana State Medical Society Meeting, French Lick, Ind.

18—Postgraduate Clinic, Rice Lake.

19—Postgraduate Clinic, Wisconsin Rapids.

20—Postgraduate Clinic, Appleton.

20—School Health Conference, Medford.

NOVEMBER

7–8—State Medical Journal Conference, Chicago.

14–17—Interstate Postgraduate Medical Association, Milwaukee.

19–20—North Central Conference, St. Paul.

29 to Dec. 2—A.M.A., Boston.

U. W. Granted $100,000 For Cancer Study

Madison, Sept. 25—The American Cancer Society has given the University of Wisconsin $100,000 for research purposes.

About $33,000 will be used by the McArdle Memorial Laboratory for research. Projects to be supported includes chemical composition of cells and particles; uncovering early cancers; trials of chemicals to halt the disease; enzyme studies and effect of nucleic acids.

* * *

Have you made plans to attend the postgraduate clinic in your area?

DEDICATION DIGNITARIES ALSO WILL INCLUDE . . .

DR. E. L. BERNHART
Society President

MRS. J. J. BOERSMA
Society Auxiliary President

DR. L. O. SIMENSTAD
Society President-Elect

MEDICAL HISTORY SECTION INSPIRES VALUABLE EXHIBIT AT CASSVILLE

Madison, Sept. 15.—The entire office furnishings and medical instruments used by the late Dr. Alfred Belitz of Pepin, Wisconsin, constitute one of the most important recent additions to the State Historical Society's Farm and Craft Museum near Cassville, according to Clifford L. Lord, director of the society.

Dr. Belitz was very much interested in the Medical History Section of the State Medical Society which is being carried out in cooperation with the State Historical Society.

Dr. Belitz practiced for more than half a century in Pepin; and in commemoration of his Golden Jubilee several years ago, the Pepin community observed "Dr. Belitz Day" and presented the doctor with a gold plaque which became one of his most treasured possessions.

In order that the State Historical Society can set up a complete "country doctor's office" in the early-day village it plans to reconstruct at Cassville, Mrs. Belitz last month sent the doctor's entire collection to Stonefield, the State Farm and Craft Museum.

His collection reflects more than half a century of medical service as he kept every copy of the Wisconsin Medical Journal and when he added new instruments he retained the old. In addition to the doctor's desk, tables, instruments, and medicine cabinets, there are the old adjustment table and dentist chair and the well-worn bag he carried on house calls.

HOUSE OKAYS OSTEOPATHS IN ARMY

Washington, D. C., Aug. 22.—The House of Representatives has passed legislation authorizing the appointment of doctors of osteopathy in the Military Medical Corps.

Dr. Frank B. Berry, Assistant Secretary of Defense, had urged the favorable action by pointing out that the availability of osteopaths would reduce the call on doctors of medicine under the doctor draft.

He added also that a presidential directive could include the osteopaths under the Doctor Draft Act. The $100 special pay would be authorized based on their commissions in the Medical Corps.

J. G. NORBY WINS HOSPITAL AWARD

Madison, Sept. 15.—Joseph G. Norby of Milwaukee, former superintendent of Columbia Hospital in Milwaukee and one-time president of the Wisconsin Hospital Association, has been chosen as the 1955 recipient of the American Hospital Association's highest honor—the Award of Merit.

The announcement was made in the August issue of HOSPITALS, Journal of the AMA.

Mr. Norby was president of the American Hospital Association in 1949 and served on its Board of Trustees from 1943–45. He retired from hospital administration in 1952.

For nearly a score of years, Mr. Norby was president of the Board of Trustees of his alma mater. St. Olaf College in Minneapolis. He is currently a hospital consultant and executive secretary of the Milwaukee County United Hospitals Fund.

PBS
PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Our helpful brochure
"How to Make Your Practice More Successful"
available on request.

Brings 400 to Mt. Horeb Daily

Gonstead Chiropractic Clinic Is 'Big Business' In Village of 1,700

By HAL ROCHE

Mt. Horeb, Wis.—The science of chiropractic has attained the status of a major industry in this Southern Wisconsin village, thanks to the effort of a former Dane County farm boy who considers 18 to 20 hours a normal daily work schedule.

Fifty-five-year-old Dr. Clarence S. Gonstead estimates that an average of 400 persons come to this village of about 1,700 population each weekday as a result of the operations of his ultra-modern clinic in the heart of Mt. Horeb's business district.

CHC VS CT

On this and following pages are a feature story, a biting retaliation by Charles H. Crownhart, secretary of the State Medical Society of Wisconsin, and an answering editorial, all of which appeared in The Capital Times, of Madison, early in August.

The story and the answers, together with the pictures, are reprinted with permission of The Capital Times.

He hastens to emphasize that not all of the visitors are patients. Some accompany friends and relatives who are scheduled for treatment at the Gonstead clinic. But their impact on Mt. Horeb business life is considerable.

"They like our cheese, butter and eggs, and patients and people with them always shop a lot while they are here," Gonstead said. **"Several merchants have told me that there is always a local business decline when I have to close up my clinic to attend conventions."**

The question immediately pops up as to why thousands of people each year make the trek from all parts of the U.S. and some foreign countries to visit a clinic in a small Wisconsin village.

"Our success rests solely on the fact that we've been successful in getting sick people well," Dr. Gonstead responded. **"People who travel a long way for treatment hear about our work from other patients. I've never advertised. My success has been built up on getting sick people well."**

The present Gonstead clinic, unquestionably this community's outstanding business building, was constructed in 1939—the result of a practice which he had been building here since 1923. Equipped to accommodate as many as 100 patients at a time, Gonstead readily admits he acquired some of the ideas for construction at the World's Fair in Chicago in 1933.

* * *

A graduate of the Palmer School of Chiropractic, Davenport, Iowa, in 1923, Gonstead returned to the farm country of his youth to start his practice that same year after practicing briefly in Madison. The long hours he put in on a farm near Mt. Vernon as a youth turned out to be excellent training for the long daily schedule he now fills as the nation's busiest chiropractor.

The clinic door opens promptly each weekday morning at 7 and Dr. Gonstead reports for duty an hour later. In the meantime, his staff of two X-ray technicians, two nurses and a receptionist ready patients for treatment. With preliminary record, X-ray and laboratory work handled by his staff with assembly-line precision. Gonstead estimates he makes the final patient adjustments in approximately three minutes.

"If I lose as little as one minute per patient daily," Gonstead said, **"I would lose several hours daily in working time."**

Gonstead is the only chiropractor on the clinic staff although he has had assistants at times in the past. His brother, Dr. Merton Gonstead, who now has his own clinic at Monroe, worked with him from 1929 through 1934.

* * *

Gonstead doesn't confine his efforts to the clinic schedule which would seem to be more than enough for one man. He makes house calls in the immediate vicinity from 6:30 to 8 in the morning and pilots his own plane—a 4-passenger Beechcraft Bonanza—on long distance calls throughout the Midwest. He has flown to treat patients as far away as St. Louis. He learned to fly in 1946 as a means of economizing on his time.

To further streamline his operations he is now in the process of building an airstrip on a 29-acre plot which he owns adjacent to his palatial residence on a hilltop near Mt. Horeb High school. He presently keeps his plane at a hangar at Truax field in Madison.

The Gonstead residence on the highest hill in this community is additional evidence of the successful practice which he has built.

Gonstead and his wife, the former Elvira Meister, Middleton, planned the home for many years, and it includes many of their own ideas. With its swimming pool and spacious layout, it looks more like a modernistic Florida hotel than the residence for two people and a caretaker. Gonstead's only complaint about the home:

"With my work schedule, I really don't have much time to enjoy it."

* * *

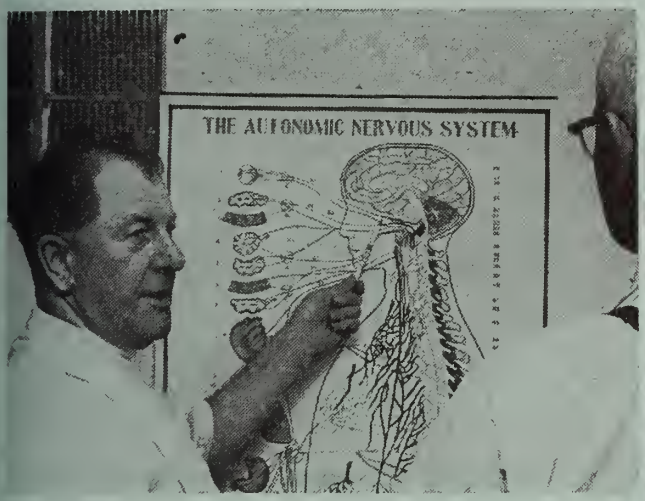
While the volume of Gonstead's patients come by bus and car from Southern Wisconsin, Northern Illinois, and Eastern Iowa, Gonstead reports he has treated people from all 48 states and some foreign countries.

He said he has treated patients from Canada, Norway, Sweden and England. Some of these are referrals from other chiropractors, but many, according to Gonstead, came because they heard about his work from previous patients.

Despite his heavy personal schedule, Gonstead holds advanced classes twice each year at his clinic for other chiropractors. About 30 enroll each November and April from all sections of the country.

Gonstead is optimistic about the future of chiropractic—

"We have scientific equipment built by the largest manufacturers in the country and spare no expense to keep up with the latest developments. Look what we've been able to do here."



Dr. Clarence S. Gonstead, 55-year-old founder of the Gonstead chiropractic clinic at Mt. Horeb, is shown above giving a patient a lecture on the nervous system prior to treatment. The procedure followed at the clinic involves record taking, interviews, X-ray and adjustment. (Photos by Tom Barlet)

Two nurses on the staff of the Gonstead chiropractic clinic at Mt. Horeb are shown above demonstrating the use of an X-ray machine which takes a picture of the full spine. Mrs. Phyllis Maurer (left) takes the part of a patient in the picture while Marlene Brattlie adjusts the clamps to hold her into position for the picture.

An average of several hundred patients come to the Gonstead chiropractic clinic each day. The modernistic building, completed in 1939, has drawn patients from all 48 states and a number of foreign countries. The clinic head, Dr. Clarence S. Gonstead, has been practicing in Mt. Horeb since 1923.

Shown above is the ranch-style residence of Dr. and Mrs. Clarence S. Gonstead which is perched on the highest hill in Mt. Horeb near that community's high school. The residence, completed in 1953, includes an outdoor swimming pool.

CROWNHART OBJECTS

THE CAPITAL TIMES,

Friday, August 5, 1955—3

Objects to Article On Chiropractor

C. H. Crownhart, secretary of the State Medical Society of Wisconsin, today objected to a feature story in The Capital Times' Green Wednesday concerning Dr. Clarence S. Gonstead and his chiropractic clinic at Mt. Horeb.

Crownhart, in a letter to The Capital Times, objected to the use of the word "science" in the story in reference to the practice of chiropractic, and the use of the title "doctor" in connection with Dr. Gonstead.

"Since when," Crownhart wrote, "has it become the practice of The Capital Times to print such personal-laudatory articles without advertising charges?"

* * *

Crownhart's letter, addressed to George R. Stephenson, executive editor of The Capital Times, follows in full:

"I read the 'Green' article re the Gonstead practice in Mt. Horeb. The color of the page was most appropriate to the contents of the article.

"I ask these questions:

"Since when did the practice of chiropractic become a 'science'? It is defined as a 'system or the practice or adjusting the joints, especially the spine, by hand for the curing of disease.' Chiropractors vociferously speak against 'science' in their protests, for example, against the fluoridation of water.

"Since when has it become the practice of The Capital Times to print such personal-laudatory articles without advertising charges?

* * *

"Since when are chiropractors 'doctors'? Wisconsin law forbids the use of the title 'doctor' or the letters 'D. C.' by chiropractors.

"The Supreme Court of Wisconsin held (State v. Michaels, 228 Wisconsin 574, 579, 580) that the use of the title is of primary use to such practitioners: 'inducing people to apply for treatment'."

CAP TIMES ARGUES

Spokesman for State Medical Group Doesn't Like the Chiropractic Story

C. H. CROWNHART, secretary of the State Medical Society of Wisconsin, has communicated his displeasure to us at a story published in this paper about G. S. Gonstad, Mt. Horeb chiropractor.

Crownhart is disturbed because the word "science" is used in connection with the practice of chiropractic and because The Capital Times printed an article about a chiropractor without charging him advertising rates—an article in which Gonstad was referred to as "doctor." We do not charge advertising rates for news stories. We consider the Gonstad story news.

Obviously, Crownhart's principal concern here is that a member of a competing trade with the medical profession got some publicity "without advertising charge," as he states in his letter. It is not surprising to hear such a complaint from the representative of the state medical society. Organized medicine has long since demonstrated that it is more interested in the economics of chiropractic competition rather than its scientific aspects. We have heard no protests when a doctor gets some free advertising.

* * *

THE FACT is that the medical profession, in recent years, is almost as active in politics and business as it is in medical science. Crownhart, who is not a doctor himself, runs the politics and public relations end of the profession. His lobbyists are active in the legislative sessions on about the same level as the brewery and other lobbyists. On the national level they have been more interested in fighting so-called "socialized medicine" than they have been in developing an anti-polio program that will work. The American Medical Association opposed a bill to make the Salk vaccine available free of charge to all children and refused to support the modest proposal of the Eisenhower administration to make it available to those who couldn't afford it.

THE CAPITAL TIMES

Published every afternoon except Sunday and Christmas by Madison Newspapers, Inc., Editorial direction by The Capital Times Company.

WILLIAM T. EVJUE .... Editor and Publisher
GEORGE R. STEPHENSON... Executive Editor
HARRY D. SAGE ..... Associate Editor
D. D. DUNN ..... Managing Editor
CEDRIC PARKER ..... City Editor

Madison 3, Wis. August 6, 1955

It is not the public interest that Crownhart speaks for in his attack on the chiropractors. It is the narrow, selfish interest of the doctors.

It is fruitless, if not ridiculous, for Crownhart to pretend that the medical profession is so dedicated to the pure science of medicine. We have not noticed this devotion manifested by the medical profession where faith healing is concerned and we suspect that in this respect it becomes more of a matter of politics than science.

* * *

THERE are many people who find relief from pain and discomfort by going to a chiropractor. There are those who swear by uranium tunnels, faith healers, copper bracelets and other charms. And there are many who find relief from going to doctors who, in some cases, actually do no more for them than the uranium tunnel does.

The chiropractors' opposition to flouridation of water is no less scientific than the medical profession's opposition to a polio vaccine program that will work, as it has worked in Denmark and Canada.

As for our printing an article about a chiropractor, we will say that so far as we know they are not outlaws. They are recognized by state law and are licensed to practice. And there are thousands of people who are treated by them —people who, despite what the state law says, call them "doctors."

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: B. Earl Clarke, M. D.

REPORT OF A CASE*

Dr. Dieter Trelle (Intern): The admitting physician saw this patient, for the first time, two days before admission. No previous medical record was available.

The patient, a 65-year-old, white housewife, was admitted to St. Luke's Hospital on Feb. 11, 1954, with the chief complaints of severe shortness of breath, cough, and pain in the right lower chest and upper abdomen of one week's duration. She was so dyspnoeic and uncomfortable that it was difficult to obtain a history. It was learned that there had been increasing exertional dyspnea for about two years. There had also been some intermittent ankle edema over the same period. During the last year there had been episodes of nocturnal orthopnea. There was no history of rheumatic fever, precordial pain, or hypertension. There had been no previous episodes similar to the present illness. The present illness started chiefly with a cough, which the patient thought was from a cold, and progressed to the present status.

Physical examination revealed a short, obese, white female. There was marked dyspnea and cyanosis. The blood pressure was 130/70. The pulse was irregular. The apical impulse of the heart was not palpable. The heart sounds were distant. There were moist rales over both lung bases. The fundi were negative. The abdomen was obese, and there was tenderness in the mid-epigastrium. The liver edge was not felt, but there was increased resistance on the right side. The bowel sounds were hypoactive. There were varicose veins of the right leg, and a history of surgical stripping of varicose veins of the left leg was obtained. There was edema of the ankles.

Interpretation of an electrocardiogram was reported as "abnormal tracing on basis of (1) auricular fibrillation and (2) nonspecific T changes."

Portable x-ray films showed "large heart with what appears to be chronic passive congestion of the lungs and possibly minimal pneumonitis in the left base . . . Abdomen—no evidence of gross pathology."

Laboratory studies revealed a hemoglobin of 12 Gm. and 4,500,000 red blood cells. The white blood cell count was 12,400 with 86 per cent polymorphonuclear leukocytes. The urine had a specific gravity of 1.011 with 1+ albumin. The sedimentation rate was 79 mm. in one hour.

Treatment included digoxin, aminophyllin, Mercuhydrin, and sedatives. The abdominal pain persisted, and there was vomiting. The bowels did not move. There was low-grade fever averaging about 100 degrees. Jaundice was first recorded on the fifth hospital day. On the morning of February 17, the patient was found to have a left hemiplegia and was confused. This persisted, and she became comatosed and died on February 22—the eleventh hospital day.

Permission for autopsy excluded permission for examination of the head.

Dr. H. H. Wright: The patient had x-ray examination of the chest on Feb. 12, 1954, and of the abdomen on Feb. 13, 1954, by films made at the bedside with the mobile unit. The limitations imposed by this type of examination and the patient's marked obesity made visualization of abdominal structures unsatisfactory. A moderate accumulation of gas can be seen in the colon, but there is no definite appearance of intestinal obstruction. The liver margin is faintly outlined, and the liver appears enlarged. The heart appears moderately enlarged. Linear densities are seen in both lungs, particularly in the perihilar regions, with some patchy densities at the left base. The changes appear most likely due to pulmonary vascular congestion with the possibility of pneumonitis, particularly at the left base.

Dr. H. L. Correll:—The history is sketchy because the patient had been observed only two days prior to hospitalization. Apparently she had complained of breathlessness for two years, with marked increase in this breath-

* From St. Luke's Hospital, Milwaukee.

lessness and the development of cyanosis the two weeks prior to admission. Right upper abdominal and lower chest pain was present for one week, as was ankle edema.

This group of symptoms, together with the x-ray reports of congestive or pneumonic changes in the lung fields, a large cardiac shadow, and large liver shadow, plus the electrocardiographic showing of auricular fibrillation led the examiners to believe heart failure was present. Although there are other explanations for these symptoms, the most common cause for this constellation is certainly congestive heart failure.

The breathlessness of two years' duration with worsening the two weeks prior to admission, together with the cyanosis, is consistent with heart failure which may be the stasis type of heart failure alone, or a combination of it with a central type from superimposed pulmonary disease.

The occurrence of right lower chest and right upper abdominal pain, not further described, needs explanation. Pulmonary infarction and/or myocardial infarction may explain the chest pain, and hepatic engorgement may explain the right upper quadrant pain.

Jaundice, not noted on admission, apparently of minor degree, and not corroborated by blood studies, could be explained on the basis of pulmonary infarction, or possibly on the basis of hepatic congestion alone. To rule out coexisting intra-abdominal disease such as gallstones, a serum bilirubin, urine test for bile, alkaline phosphatase determination, and notation of stool color would have been helpful. Particularly is this true in view of the persistent abdominal pain, which suggests intra-abdominal disease, which may or may not be associated with congestive heart failure.

The late occurrence of a left hemiplegia suggests cerebral embolization or thrombosis, more probably the former.

Assuming congestive heart failure to be present, can we assemble these findings under a common cause?

Valvular heart disease with auricular fibrillation and pulmonary, cerebral, and intra-abdominal embolization can explain the entire picture; but characteristic heart murmurs and the usually expected alterations in heart sounds are not described. While these findings may be absent in heart failure, their absence makes the diagnosis of valvular heart disease unlikely. Similarly, bacterial endocarditis, which can cause all these findings, must be considered as not established.

Hypertension was not present historically or during the period of observation, and the retinal arterioles showed no changes to suggest its longstanding presence. Arteriosclerotic heart disease with myocardial infarction is a common cause for heart failure in persons of this patient's age group. The absence of confirmatory electrocardiographic changes does not eliminate the possibility. Mural thrombi in the auricles associated with heart failure and auricular fibrillation, or in the ventricles from septal infarction, are a frequent cause of pulmonary, cerebral, and renal infarction and occasionally cause mesenteric infarction, thus explaining the chest pain, fever, jaundice, obstipation, persistent abdominal pain, emesis, and terminal left hemiplegia, as well as the congestive heart failure with large heart and large liver.

Another consideration in all cases of heart failure of undetermined etiology is the heterogeneous group of myocarditides. This group includes toxins; infections, often viral; disease of collagen tissues; allergic reactions; vitamin deficiencies; and anemias. Mural thrombosis in the heart, with embolic phenomena, occurs in many of these, and arteritis with thrombosis in some, which might possibly account for the widespread lesions evidenced in this case.

Lastly, the possibility of heart failure plus a primary intra-abdominal disease must be considered and cannot, from the information available, be ruled out.

From a standpoint of frequency with a single etiology, however, the first consideration would appear to be myocardial infarction with infarctions of the lungs, brain, and possibly kidneys or other intra-abdominal organs. The second consideration would be myocarditis of nonspecific type with similar embolic complications.

Dr. B. Earl Clarke: As has already been stated, permission to open the head was not obtained. From the clinical findings and the fact that embolic lesions were found elsewhere, I think we can accept as fact an intracranial vascular accident.

We still have the orthopnea and cough, the cyanosis, the circulatory failure, and the abdominal pain to be explained.

Because the clinical attention was centered on the heart and circulatory failure, with chronic passive congestion, we shall dispose of that first. There was no chronic passive congestion. In the first place, there was no cardiac cause for such congestion. The coronary arteries were in excellent condition. There was no myocardial infarction. The heart valves were all essentially normal. There was no history of hypertension and no hypertrophy of the left ventricle.

The liver weighed 1,600 Gm. It was uniformly dark reddish-brown in color. The anterior margin was considered to be somewhat rounded. Microscopically, the sinuses contained considerable blood, suggesting acute or recent congestion. There was no chronic passive hyperemia. It is therefore obvious that the long history of increasing shortness of breath and cyanosis cannot be explained on the basis of chronic passive congestion.

The lungs were rather heavy. The left weighed 610 Gm., and the right weighed 620 Gm. The pulmonary vessels were normal. There was a small amount of mucopurulent material in the large bronchi. The lung tissue was rather firm, and crepitation was poor. This induration was most marked in the lower lobes, but the upper lobes were also involved. There was no brownish discoloration such as would be expected in the "brown induration" of chronic passive congestion. Microscopically, there were no "heart failure cells."

In all sections of the lungs there was a remarkable interstitial fibrosis of the alveolar walls. In some there was a rather new or loose fibrous tissue and, in this, sparely distributed lymphocytes and monocytes. In other places there was much more collagen. This was sometimes in bulbous or rounded masses. Sometimes such areas had a surface covering of capillaries. In other areas, thought to be older lesions, the capillaries were gone. This left a dense, thick alveolar wall; and the remaining small alveolar spaces were lined by a single row of cuboidal or columnar cells.

We have, then, a condition of diffuse interstitial fibrosis of the lungs or, clinically, the Hamman and Rich syndrome. The cases of Hamman and Rich were more acute, but subsequent reports indicate that the condition is most often chronic and progressive. This adequately explains this patient's symptoms up to one week before her admission.

We return to the heart. I have already indicated that grossly it was not remarkable. It weighed 360 Gm. There was perhaps some dilatation; but dilatation, unless of considerable degree, is difficult to evaluate. The myocardium was rather soft and flabby. There were mural thrombi in the right ventricle. Microscopically, there was a diffuse inflammatory reaction of the interstitial tissues, associated with focal areas of degeneration of myocardial fibers. The inflammation was manifested by edema and rather diffuse exudation of lymphocytes, plasma cells, large mononuclear cells, a few eosinophils and, in one or two places, neutrophils. While this exudation was diffuse, it was most marked about small arterioles. Some arterioles showed endothelial proliferation that narrowed the lumina. One or two were found with necrosis of the wall and exudation into the tissues of the wall. In places, the large mononuclear cells were numerous; but they were never in discrete formations that suggested Aschoff bodies. There was sparse exudation of the same sort into the epicardium, and occasionally there were collections of leukocytes immediately beneath the endocardium.

It is customary to divide myocarditis into secondary and idiopathic or isolated. In this case, is the myocarditis secondary to the pulmonary pathology or is the association only coincidental? I have not found a report of these two conditions being associated. Some students believe both conditions to be virus infections. Some believe the myocarditis to be an allergic reaction. Is it possible that in our case the myocarditis is the result of hypersensitivity to the virus that caused the pulmonary pathology? Such speculations seem rather pointless. We do know that this patient had a diffuse myocarditis, and this seems to explain adequately all of the symptoms and signs of the terminal illness.

I cannot say all without including the abdominal pain. The peritoneal cavity contained 400 cc. of bloody fluid. The omentum was adherent about the spleen. When it was removed, more than half of the spleen was found to be infarcted and the capsule over this necrotic portion was ruptured. The splenic artery was occluded by a red throm-

bus. As was mentioned above, there were mural thrombi in the right ventricle. It seems reasonable to assume that the infarction of the spleen and of the brain was the result of embolism from similar mural thrombi in the left heart.

Doctor Correll attempted to find a single etiological basis. He has done a splendid job, and his reasoning is logical. However, unless we believe the myocarditis to be secondary to the pulmonary condition, we must accept two basic lesions.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1955, the March of Medicine began its tenth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 39 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WATK	Antigo	Saturday	8:45 a.m.
WHBY	Appleton	Saturday	8:30 a.m.
WATW	Ashland	Saturday	8:15 a.m.
WHSA	Brule	Saturday	1:15 p.m.
WHKW	Chilton	Saturday	1:15 p.m.
WCHF	Chippewa Falls	Saturday	9:00 a.m.
WHWC	Colfax	Saturday	1:15 p.m.
WHAD	Delafield	Saturday	1:15 p.m.
WEAU	Eau Claire	Saturday	11:45 a.m.
KFIZ	Fond du Lac	Saturday	4:00 p.m.
WBAY	Green Bay	Saturday	2:45 p.m.
WHHI	Highland	Saturday	1:15 p.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	10:45 a.m.
WLDY	Ladysmith	Saturday	9:30 a.m.
WHA	Madison	Saturday	1:15 p.m.
WIBA	Madison	Saturday	11:00 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Saturday	11:45 a.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	8:30 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WPLY	Plymouth	Saturday	8:30 a.m.
WIBU	Poynette	Thursday	2:45 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:15 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WRDB	Reedsburg	Tuesday	9:30 a.m.
WOBT	Rhinelander	Saturday	9:05 a.m.
WHRM	Rib Mountain	Saturday	1:15 p.m.
WJMC	Rice Lake	Saturday	9:45 a.m.
WRCO	Richland Center	Wednesday	1:30 p.m.
WTCH	Shawano	Sunday	6:45 p.m.
WLBL	Stevens Point	Saturday	1:15 p.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m
WTTN	Watertown	Tuesday	11:30 a.m.
WSAU	Wausau	Saturday	9:15 a.m.
WBKV	West Bend	Saturday	11:30 a.m.
WHLA	West Salem	Saturday	1:15 p.m.

Preparation For Parenthood

As It Looks to Your State Board of Health

IN THEIR desire to be effective parents, many young people seek training and education for parenthood, just as they do for other new experiences in life. This need is intensified today because smaller families have provided little or no opportunity for young people to learn about children in their own homes. Other social changes and world conditions are resulting in confusion and unsureness in many individuals. Facing the experience of parenthood, with its increased responsibilities and changes in one's way of life, adds to this feeling of insecurity. Is it surprising that a young mother is anxious and tense when handling and caring for her first baby? In addition, ideas about childbirth and about raising children are often based on superstition, hearsay, and even more dramatic accounts in literature and on the movie screen. So it is only natural for young people to seek help.

Wisconsin physicians recognized this need of parents. In 1950, the State Medical Society, through its Division on Maternal and Child Welfare, recommended "consideration of the use of group teaching for prenatal patients based on plans worked out cooperatively with physicians." A survey of hospitals in the state had indicated little was being done to send the new mother home with experience and understanding in caring for her new baby.

Expectant parent classes can supplement medical care through helping young people gain an understanding of how children grow and develop. This leaves the physician free to individualize his counseling of patients, according to their specific needs.

Class discussions center around the common problems and expectations of young parents. In all of the classes an attempt is made to relieve the prospective parents of their unsureness and to build up confidence. Exactly how this is done varies with each group. Something common to all is the reassurance gained through sharing ideas with others facing the same experience. Should physicians wish their patients to have instructions in "natural childbirth," special arrangements need to be made for this, as it is not part of the regular class program.

In 1947, there were expectant parent classes in five Wisconsin cities. At present, they are sponsored by 34 city or county health agencies. All classes are first approved by local physicians. Usually a public health nurse serves as the group leader, although some Milwaukee hospitals have also initiated classes. Guidance and resource materials are available through the State Board of Health. Most of the classes have been limited to mothers, with fathers included for part of the course if both groups want such an experience.

Parenthood classes help to attain the goals of public health which aim at prevention of illness or disability and the building of positive attitudes toward health. Other groups with qualified personnel and adequate medical supervision can initiate expectant parent classes where there are none in a community. Many agencies have contributions to make to such classes. The visits to hospitals, now a part of many plans, have provided a very valuable orientation for prospective parents. It is becoming increasingly important that efforts be coordinated for the best interests of parents and their children. In any event, classes need constant review so that they will continue to meet some of the needs of expectant parents and supplement the services of physicians in a positive and constructive way.—MISS FRANCES PORTER, R. N., *Public Health Nursing Consultant, Bureau of Maternal and Child Health.*

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

ASPIRIN IN GASTRIC DISTRESS

In a series of tests made by Muir and Cossar,[1] they found in gastrectomy specimens that 12 out of 20 patients receiving a commercial brand of aspirin had the characteristic mucosal reactions of acute gastritis. These signs were especially marked in the pyloric antrum and in the lesser curvature. The mucosa was congested and edematous with the mucus containing small particles of the drug. Multiple erosions were visible in 5 patients and microscopically seen in fixed preparations in all of the rest. In 3, aspirin particles were firmly adherent and had to be mechanically picked from the eroding ulcers. In one instance, one-half of an aspirin tablet was found firmly embedded in the mucosa of the lesser curvature. The mucosa containing the embedded aspirin was typical of an acute peptic ulcer rather than a simple erosion. In another series of 20 patients receiving hard tablets of aspirin, 8 presented evidences of acute erosive gastritis, which appeared to be less severe than that in those receiving ordinary aspirin. This was apparently due to the fact that the solid or relatively hard tablets were more or less surrounded by a coating of protective mucus. Evidently, then, the walling off by the mucus served as a protective process, whereas a failure to wall off the particles resulted in a more marked tissue damage.

Eighteen patients who had received a freely water-soluble preparation of aspirin appeared to be relatively free from the mucosal reactions, since in only 2 patients were mild reactions observed.

Microscopically, most of the specimens presented evidences of chronic gastritis with but 10 per cent showing evidences of ulceration. Clinically, some 300 patients with peptic ulcer were questioned relative to their subjective sensations after taking aspirin on their own responsibility. Approximately one-third admitted that they were well aware of the likelihood of a "bout" with dyspepsia due to the drug. The results were heartburn and a probability of "ulcer pain" providing they had not eaten shortly prior to taking the drug.

In a total of 166 patients having had bouts with hematemesis, one-third admitted to having taken aspirin within six hours prior to their hemorrhage. The authors believe that, in general, "aspirin hematemesis" is very likely due to an erosive gastritis due to the drug rather than to an erosion or exaggeration of a pre-existing ulcer prone to hemorrhage. Furthermore, they state that they could not find any convincing evidence that the hemorrhage was due to a defective capacity of the blood to coagulate; in other words, there appeared no evidence of any prothrombin deficiency in the blood. Therefore, the hemorrhage was considered to be a result of the corrosive action of the drug.

Pertinent to this action of aspirin was the observation made by a personal friend of the writer of these comments who had a toothache at the time a fishing trip was scheduled. An aspirin tablet placed at the side of the aching tooth temporarily alleviated the ache. By the next day, however, there was noted a deep erosion of the gum at the site of application of the drug, thus again and uniquely demonstrating its capacity to erode wet mucous membranes.

In conclusion, the investigators, Drs. Muir and Cossar, suggest that aspirin (or officially in the U.S.A., acetylsalicylic acid) "should never be given to patients with peptic ulcer" or to those who experience gastric distress of any grade due to the drug itself. The soluble calcium salt of the drug, administered in aqueous solution, appears to be relatively freer from irritant effects and probably should be employed when salicylates are clearly indicated.—A. L. TATUM, M. D.

REFERENCE

1. Muir, A., and Cossar, I. A.: Aspirin and ulcer, Brit. M. J. 2:7–12 (July 2) 1955.

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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Volume 54 SEPTEMBER 1955 Number 9

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Address all communications to THE WISCONSIN MEDICAL JOURNAL, Box 1109, Madison 1

Education Versus Service*

Many hospitals in Illinois do not have their quota of interns; some have none at all. This situation is not peculiar to our state; it is nation wide. One reason is that there are 3,000 more approved internships than there are interns to fill them.

Competition is keen yet some hospitals are successful year after year in filling their rosters. What is their secret? The report of the Advisory Committee on Internships to the Council on Medical Education and Hospitals may offer a clew. The report states:

"When an attending staff realizes that teaching takes time worth dollars in the office, when the staff cherishes the continuously broadening viewpoint that comes from day after day of give and take with interns, the intern roster usually is overfilled, although paint may peel from the walls of the living quarters and stipends be nominal. For such a staff spirit can so illuminate bedside teaching that the interns' progress toward clinical maturity through supervised, graded responsibility is assured. No tennis courts, television sets, kitchenette apartments, or printed lists of conference can substitute for this spirit in giving an intern a feeling of function.

The more famous and widely sought after municipal or county services in this country cannot always be distinguished from less popular services by ward equipment, house staff pay, or indeed by laboratory buildings. They can be distinguished by the freedom and content of communication among the little knots of men and women who serve the wards, operating rooms, autopsy rooms, and laboratories regularly, day after day. On the other hand, we are all acquainted with hospitals which, despite superb physical plants and high stipends, are not always successful in attracting an intern staff. Some of these are private hospitals; a few have large public wards."

Hospitals meeting these qualifications are few and far between. Nevertheless, this type of institution attracts the more mature graduate who appreciates the need for continued study and the benefits to be derived from associating with a staff "who have remained students of medicine."

But many students will settle for less. Those who are in debt or have a growing family to support may select the place offering the most money or the closest to home. Interns who are influenced by the social trends that began in the Roosevelt regimen expect to be spoon-fed. For them, the living quarters, number of nights off, and the 9 a.m. to 5 p.m. working schedule are of the utmost importance. They are convinced that hospitals exploit interns and should pay for services rendered.

* Reprinted by permission from July, 1955, *Illinois Medical Journal.*

Between these extremes are the majority of seniors who want to intern in a hospital that offers an education as well as a place to care for the sick. They are willing to render service, provided the staff reciprocates with bedside instruction and constructive criticism. Good patient care and education go hand in hand and the attending physician who expects service without giving instruction is as off the beam as the intern who expects education on a 9 to 5 basis.

From the intern's point of view, the attending physician who is too busy to instruct is of little value to him even though highly skilled in the practice of medicine. Hospitals so staffed may have an excellent reputation in the community but they never seem to attract interns.

How can the situation be remedied? The cooperation of the staff is vital. Unless the busy man is willing to take time to teach, additions to the staff may be needed. This would provide an excellent opportunity to add younger men willing to spend part of their time with the interns in the hospital.

Encouraging Progress

The announcement that a sixth school for practical nurse training hopes to open in Wausau in January, 1956, will be greeted with cheers by physicians of northern Wisconsin. Nurses who will really "nurse" are one of the physician's greatest needs. This is especially true in north central and northern Wisconsin, where fewer and fewer of the girls who leave the area to attend professional nursing schools in southern Wisconsin return to their home areas.

The Superior practical nursing school had a slow beginning, but the State Department of Vocational and Adult Education reports that it has finally "caught on" and is currently filled with 90 applicants. In the cities in southern Wisconsin where practical nursing schools are located, the demand is so great for their services that graduates are "gobbled up" before they can even think of packing their bags to go back home.

Even more encouraging is the possibility of a new school at Fond du Lac and an additional school in Milwaukee. Fond du Lac physicians have been instrumental in arranging meetings to develop the full support of physicians, hospitals, and nurses in that city. In Milwaukee, Sacred Heart Sanitarium and Alverno College are seeking to establish a TPN school and are thinking of a possible tie-in with Beaver Dam or Waupun hospitals. This kind of thinking is good.

Undoubtedly, the Committee on Nursing Education of the State Medical Society's Council on Medical Service has had an influence in this expansion of practical nurse schools. The committee has made intensive efforts during the past three years to obtain financial support for such developments and to encourage the location of schools in areas of the state where they are most needed.

National Teaching Program Available to Wisconsin MD's in November

For the first time in many years the Interstate Postgraduate Medical Association International Scientific Assembly will be held in Milwaukee, on November 14–17. The program will present a variety of clinics, papers, and panel discussions by outstanding American and Canadian medical teachers.

Doctor Charles Mayo, Rochester, Minnesota, is president; and Wisconsin trustees are R. G. Arveson, M. D., Frederic, and Erwin R. Schmidt, M. D., Madison. The program for the 1955 meeting was developed under the direction of Doctor Schmidt, with a special committee, on which F. W. Madison, M. D., Milwaukee, served.

Those desiring full information on the program are asked to write: Interstate Postgraduate Medical Association, 16 North Carroll Street, Madison 3.

. . . . THE PRESIDENT'S PAGE . . . .

YOU are driving along the highway at night. Only the bright headlights of your automobile light up the ribbon of concrete before you. You would like to be at the lodge in time to get a few hours' sleep before getting out on that trout stream in the morning. Maybe a few miles faster . . . nobody on the road this late at night. Sixty-five . . . seventy . . . seventy-five.

Suddenly there looms out of the darkness the steady flicking of the red light atop a highway patrolman's car. There are flares on each side of the roadway. Several automobiles are stopped on the shoulder. You slow down to a crawl. The traffic officer warns: "Take it easy through here . . . there's been a bad accident."

You see the two mangled automobiles—one upturned, the other on its side in the ditch. You stop to make sure that medical care has been rendered. You see the seemingly too familiar scene: a motionless human form covered with a blanket, another form unconscious—who knows how long he may live?

The ambulance arrives and takes the injured to the emergency room of the local hospital. More names go into our *great record book* of traffic deaths—a *record* across the nation of 38,000 killed each year—a *record* right here in Wisconsin of 23 killed over the 1955 Labor Day weekend. A national *record* of 2,000,000 injured and of $4,300,000,000 in waste! A *record* is usually something of which to be proud!

You think: Is this civilization? What kind of a slaughter is this? When will a truce be called? What is being done about it?

You get back into your car and try to think of that trout stream again. You have more time to get there now—it seems. You just don't have to be in a hurry. A little slower around this next curve. Hold it down to fifty . . . maybe fifty-five. Plenty of time to go fishing after you arrive safely . . . and alive!

Yes, a bad accident is a great lesson for an eyewitness—for a few days. But it wears off quickly. We, as physicians, must lead the greatest of all teaching jobs before us. It is well known that medical science has accomplished a colossal feat in extending man's life span to over 70 years. We have licked one dread disease after another and have come up with wonder medications to keep us healthy and hearty.

But the shame of the nation is still with us. Results from all accidents each year leave 95,000 persons dead and 350,000 permanently impaired. A total of $10 billion is wasted because of these accidents.

The problem is the greatest among those which it is easy to "talk about" and then do nothing.

I feel that it is not only my responsibility but my duty to personally urge each and every physician in the State of Wisconsin to take it upon himself to wage a sincere educational campaign among his patients, friends, and colleagues as his contribution to solving this shameful situation. We cannot expect to prevent *all* accidents, but we can prevent *careless* accidents!

I am confident we can lead the way!

Irvin L. Bernhart M. D.

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Transactions of the 1955 Regular Session, House of Delegates, State Medical Society of Wisconsin

FIRST SESSION

Tuesday, May 3, 1955

The opening session of the House of Delegates of the State Medical Society of Wisconsin, held at the Schroeder Hotel, Milwaukee, convened at 7:45 p.m., Dr. L. O. Simenstad, Speaker of the House, presiding.

Report of Committee on Credentials

The Committee on Credentials was composed of Drs. J. W. Fons, Milwaukee, chairman; P. H. Gutzler, River Falls; and M. V. Overman, Neillsville.

The committee verified the registration of 37 delegates and 18 alternate delegates entitled to vote at this session of the House of Delegates. In addition, five councilors and two officers registered their attendance.

On motion of Doctor Fons, seconded by Dr. E. C. Cary, Reedsville, carried, the attendance roll totaling 55 was accepted as the official roll of the session of the House, to stand for the entire session.

Announcement of Reference Committee Appointments

Speaker Simenstad announced the following appointments to reference committees:

Reference Committee on Reports of Officers: Drs. S. A. Morton, Milwaukee, chairman; W. D. Stovall, Jr., Brodhead; H. J. Kief, Fond du Lac; E. W. Humke, Chilton; and R. A. Thayer, Beloit.

Reference Committee on Reports of Standing Committees: Drs. G. W. Carlson, Appleton, chairman; E. C. Cary, Reedsville; G. C. Hank, Madison; C. A. H. Fortier, Milwaukee; and R. S. Hirsch, Viroqua.

Reference Committee on Resolutions and Amendments to the Constitution and By-Laws: Drs. T. W. Tormey, Jr., Madison, chairman; Donald Willson, Milwaukee; H. A. Aageson, Oconto; W. C. Henske, Chippewa Falls; and E. D. Sorenson, Elkhorn.

Minutes of 1954 Session Approved

On motion of Dr. E. C. Cary, Reedsville, seconded by Dr. W. D. Stovall, Jr., Brodhead, carried, minutes of the 1954 regular session of the House of Delegates, as printed in the December, 1954, issue of *The Wisconsin Medical Journal*, were approved.

Standing Rules Adopted

On motion of Dr. W. C. Henske, Chippewa Falls, seconded by Dr. W. D. Stovall, Jr., Brodhead, carried, the following standing rules as adopted in previous sessions were adopted for this session of the House:

1. Without permission of the House, reports of officers be limited to 20 minutes.
2. Without permission of the House, supplementary reports of committee chairmen or members be limited to five minutes.
3. Rule 7, Robert's Rules of Order (1915 Ed. p. 39) be modified by the provision that no member can speak longer than five minutes at a time in debate without permission of the House.
4. The Committee on Nominations shall remain in open session for one hour to hear any delegate or alternate (or other member of the Society) who may have suggestions, after which it may proceed in closed session.
5. Roll calls:
   a. An alternate delegate is alternate for a specific regular delegate and cannot serve as a "roving" alternate delegate.
   b. There is no provision recognizing bloc voting by a county society. On roll call, individual delegates or alternate delegates or specially appointed delegates will be specifically polled as to their vote.
   c. If a delegate registers but is absent for some portion of a session, his alternate delegate cannot vote. Once the delegate registers for one of the three sessions, he is the accredited representative of the county society for the duration of that session.
   d. If an alternate delegate first registers with credentials that have been supplied him, and is recorded on the report of the Credentials Committee, and some time during the course of the session the regular delegate appears, it is the alternate delegate who is entitled to vote.
   e. At the 1949 session, the House approved the motion that in order to facilitate contested elections in the future, the system employed by the American Medical Association be utilized wherein the roll call of registered delegates is called from the Speaker's rostrum, and as the name is called, the delegate or alternate comes up and deposits his ballot, so that there can be an accurate count against registration.
6. Delegates and alternates will sign registration slips at the time they are admitted to each session of the House. Their names will be checked against a list of authorized delegates and alternates previously submitted by the county societies to the state headquarters. If an uncertified delegate wishes to be admitted, he will be referred to the Credentials Committee for its recommendation as to whether he should be admitted.
7. The registration of those in attendance at the House of Delegates other than as voting delegates should be handled at a separate registration table.

8. The Credentials Committee should be seated at the registration table to handle any problem that may arise, and in particular, the matter of seating an alternate at a session when the delegate himself cannot be present.

Reports of Officers

The following report of the Council was printed in the *Handbook for Delegates:*

REPORT OF THE COUNCIL

R. G. Arveson, chairman.

In making its annual report to the House of Delegates the Council must emphasize that the changeover from a fall meeting to a spring meeting has necessarily resulted in an inability for the Council, its several committees, and the staff to complete projects to the extent ordinarily possible.

Several matters warrant emphasis and are reported as follows:

The Commission on Prepaid Plans

This Commission, which has issued a separate report, is directly concerned with the operation of Blue Shield of Wisconsin and certain activities related to the health insurance field. Its members are among the most active of any in the organization's committee structure.

At its own request the structure of the Commission has been slightly changed to permit greater geographic representation. Henceforth, it will consist of the president and president-elect of the Society and 20 physicians whose appointments are arranged so that approximately one-third expire each year.

The Wisconsin Interprofessional Institute

In October, 1954, Dr. H. Kent Tenney, Jr., of Madison, retiring president, recommended the organization of periodic interprofessional institutes in Wisconsin, a proposal which the House approved.

The first institute was held in January, 1955, and a number of organizations were invited to send participants. These organizations included the Wisconsin Conference of Catholic Hospitals, the Wisconsin Hospital Association, the Wisconsin Pharmaceutical Association, the Wisconsin State Dental Society, and the Wisconsin State Nurses Association. Representatives also attended from the State Boards of Dental Examiners, Health, Medical Examiners, Pharmacy, Nurses, and Public Welfare, and from Marquette University School of Dentistry, Marquette University School of Medicine, and the University of Wisconsin Medical School.

Topics were many and varied, including a presentation by the Honorable Vernon W. Thomson, attorney general of the State of Wisconsin, on "Rule-Making Powers of State Boards," and discussions on public health education in oral health, the Hospital Construction Act, nursing care, hospital dental service, the aging population, and the significance of withdrawal of federal funds from certain public health activities in Wisconsin.

The conference lasted two days, and comments from those who participated were unanimous in their praise and approval of its continuation.

As a new venture, its mechanisms and procedures have not been fully developed, but in the future, the Council feels that some mechanism for reporting what transpired should be developed so that the membership of the Society may be fully informed. All participants were provided with a 180-page transcript of proceedings, and the tradition was established that the institute be in the nature of general discussion without any formal action being taken by participants.

Scientific Sections and Delegate Representation

This subject has had sporadic study during the past several years, arising out of the belief of a great many physicians that the true organization of the House of Delegates should be that of representation from county medical societies.

Therefore, the Council recommends the following amendments to Chapter XIII of the By-Laws.

> "Section 1. The House of Delegates shall, *if so recommended by the Council* from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established."
>
> "Section 6. Each section so established shall have the privilege of electing a *non-voting* delegate and alternate to the House of Delegates." (New material in italics.)

Charitable, Educational, and Scientific Foundation of the State Medical Society

For some time the leadership of the Society has been aware that a number of its members, as well as friends of medicine, were or could be interested in making grants or contributions to projects within the province of the medical profession. Such grants, if made to the Society, would not be deductible by the givers for income tax purposes, a fact which has very likely been a deterrent to such gifts.

About three years ago the Society established a trust called the Student Loan Fund, designed to acquire funds for loans to needy medical students. This was a tangible effort to solve an important problem through a closely affiliated organization.

It has become increasingly evident that it would be desirable to establish a single organization which could receive charitable, educational, and scientific contributions from physicians and others and administer them in accordance with the intention of the givers or the best judgment of the management of such a body. Such an organization is commonly referred to as a "foundation." When it is organized in accordance with state and federal income tax laws, such an organization is *exempt* from such taxation.

Further, gifts or grants made to such an organization are *deductible* by the givers, whether they be individuals or corporations. Dual exemption thus makes a foundation attractive in these days of high taxes.

At its May, 1954, meeting, the Council authorized the study and preliminary organization of such a foundation. Experience has demonstrated that the overwhelming majority of such organizations take that form, because their continuation is not so directly dependent upon individuals, as in the case of a trust or unincorporated association. Further, there is a tendency on the part of givers to prefer that the object of their gifts be a corporation, and they attach an increased stability and likelihood of survival to an incorporated foundation.

Therefore, the Council has recommended the incorporation of a Foundation, governed by a Board of Trustees composed of (1) the Council of the Society and (2) an elected representative from each component county society. It is further recommended that the officers and members of the Executive Committee of the Foundation be trustees who are also members of the Council. Terms of the county society members could be for three years and so staggered that approximately one-third would be elected each year, thereby helping assure stability. That would automatically be true in the case of Council members.

You will note that no reference is made to membership. The Wisconsin Statutes on nonstock corporations no longer require members, and it is possible to operate entirely with a governing board. Since no member would have vested rights in the Foundation in the sense that a practising physician does in his medical society or in his hospital staff, it is believed preferable to dispense with membership as part of the structure of the Foundation.

While this would mean a board of approximately 70 members, if the officers and Executive Committee both came from the Council this would be a small enough number to be workable. It seems basically important that there be a representative in each county society who will be informed in the affairs of the Foundation and who can handle inquiries, contributors, candidates for loans or grants, and other matters. This effective continuing liaison at the county level might assure the success of the Foundation better than any other single device.

As the officers and Executive Committee would come from the Council, or board of trustees of the State Society, the tradition and continuity of organized medicine in this state would be assured. The Foundation should be thought of as an additional arm under direct management of the governing body of the Society itself.

The potentialities of the Foundation are almost unlimited. Many unsolved scientific, educational, and economic questions have grown out of or are related to the practice of medicine today. They are the subject of much speculation and much writing for which there often exists no adequate factual basis. Many statements are made in government circles which represent either inadequate studies or confused conclusions. Medicine has a direct obligation to the people, as well as to itself, to determine or review facts underlying such problems and, where necessary, to state, restate, or correct conclusions. The very freedom of medical science may be dependent upon the manner in which these problems are studied and presented to the public. All too often the public accepts what appears to be an answer but what, in fact, is not an answer. The medical profession should study these problems and propose their solution, as a matter of qualification, public interest, and legitimate self-interest.

It is being positively asserted in some quarters today that physicians are encouraging excessive use of hospital facilities. The more fundamental question, of course, is the effect on the public health of the new drugs, new uses of blood, and other new scientific technics developed in the last 20 years. The frequency and duration of hospitalization are among the details of the much more fundamental question, but the details have been emphasized, and the question overlooked.

The Foundation could make grants for such a study much more objectively than insurance companies, Blue Cross, or even Blue Shield. On the other hand, it could receive funds from those sources provided there were no restrictions placed on the study.

Recently, a committee of the Medical Society has made a study of the causes of maternal deaths in the State of Wisconsin. It is now making a study of the closely associated subject of neonatal deaths. All such studies cost money. If several of them were to be conducted at one time, they could impose a heavy drain on the current dues structure or the reserves of the Society.

The advisability of enlargement of funds for loans to medical students would seem obvious. Much more complex would be the development of mechanisms for making grants to disabled physicians who might otherwise be public charges in part or in whole. Other professions have developed such mechanisms, and these clearly fall within the category of direct charity.

The medical profession, or certain of its members, might be interested in having special studies made in fields for which no other grants were available. Medical men have commented that a few of the fields and problems of medicine have relatively generous funds available for their study at present, while others have nothing. The Foundation might be able to correct this inequality in some measure. If such a Foundation were already organized and had the funds available to it, undoubtedly its trustees would desire to make a substantial annual contribution to the American Medical Education Foundation.

The above list could be greatly expanded, but it is believed that it furnishes enough examples to demonstrate the potential breadth of the interests and functions of such a Foundation.

Recommendations

The following final recommendations are offered for consideration by the House of Delegates:

1. Authorize the formation of a Foundation along the lines indicated in this report.

2. Administer the Student Loan Fund of the Society if its trustees are willing to turn those funds and their administrative responsibilities over to the Foundation.

3. In the course of educating the membership to the existence and purposes of the Foundation, emphasize that gifts and grants should be made in broad terms, or in the alternative, so that if a par-

ticular problem has been solved before the funds are received, or reaches satisfactory solution before the funds have been fully expended, they can be diverted to other uses by the Foundation. Such alternative uses could be determined by the Foundation trustees unless they had been prescribed by the givers.

4. Establish the amount of annual contributions from the membership on a *voluntary* basis. The "billing," or notice, should be only by way of convenience and reminder. Such contributions should not be asked or expected of those under 35, but all other active members should be encouraged to contribute annually.

5. Urge physicians to include the Foundation in their estate planning, particularly after making provision for their immediate families.

6. After the Foundation is underway, consider adding interested laymen to the Board of Trustees and also seeking to attract grants from industry and other sources for specific studies and other purposes.

Proposed Articles of Incorporation and By-Laws of the Foundation, approved by the Council, are now submitted to the House for its action.

CHARITABLE, EDUCATIONAL, AND SCIENTIFIC FOUNDATION INCORPORATED OF THE STATE MEDICAL SOCIETY OF WISCONSIN

ARTICLES OF INCORPORATION

The undersigned natural persons of the age of twenty-one (21) years or more, acting as the incorporators of a corporation, hereinafter referred to as the "Corporation" under the provisions of Chapter 181, Wisconsin Statutes, known as "The Wisconsin Non-Stock Corporation Law," hereinafter referred to as the "Act," adopt the following Articles of Incorporation for such Corporation:

Article I

Name

The name of the Corporation is Charitable, Educational, and Scientific Foundation Incorporated of the State Medical Society of Wisconsin.

Article II

Duration

The period of the Corporation's existence is perpetual.

Article III

Purposes; Powers

Section *1. Purposes.* The exclusive purposes and objects of the Corporation are to engage in, assist, and contribute to the support of charitable, educational, and scientific activities and projects and to contribute to the support of, and to create and maintain, charitable, educational, and scientific institutions, organizations, and funds of any and every kind.

Section *2. Powers.* Subject to any specific written limitations or restrictions imposed by the Act, by other law, or by these Articles, the Corporation, as to both its income and assets, shall have and may exercise any and all of the powers specified in Section 181.04 of the Act.

Section *3. Limitations.* The Corporation shall not be operated for profit; and the foregoing objects, purposes, and powers are each and all subject to the limitations that no part of the net earnings of the Corporation shall inure to the benefit of any private individual, that no substantial part of the activities of the Corporation shall consist of carrying on propaganda, or otherwise attempting to influence legislation, and that no donation, gift, contribution, or loan shall be made to any organization, a substantial part of the activity of which is carrying on propaganda, or otherwise attempting, to influence legislation.

Article IV

Members

The Corporation shall have no members.

Article V

Board of Trustees

The number of trustees constituting the initial Board of Trustees is three (3), and thereafter may be such number not less than three (3), as is fixed from time to time by the by-laws.

The by-laws shall prescribe the qualifications of the trustees, the manner of their election, terms, and the manner of termination of trusteeship.

The names and addresses of the trustees constituting the initial Board of Trustees are:

Arthur J. McCarey, M.D.—305 East Walnut Street, Green Bay, Wisconsin

E. L. Bernhart, M.D.—2714 West Burleigh Street, Milwaukee, Wisconsin

H. Kent Tenney, M.D.—1 South Pinckney Street, Madison, Wisconsin

Article VI

Location of Principal Office; Name of Initial Registered Agent

The location of the principal office of the Corporation shall be the City of Madison, Wisconsin.

The name and address of the initial registered agent of the Corporation is C. H. Crownhart, 704 East Gorham Street, Madison, Wisconsin.

Article VII

Data Respecting Incorporators

The names and addresses of the incorporators of the Corporation are:

Arthur J. McCarey, M.D.—305 East Walnut Street, Green Bay, Wisconsin

E. L. Bernhart, M.D.—2714 West Burleigh Street, Milwaukee, Wisconsin

H. Kent Tenney, M.D.—1 South Pinckney Street, Madison, Wisconsin

Article VIII

Disposition of Assets Upon Dissolution

In the event of the dissolution of the Corporation, its net assets shall be transferred only to organizations organized and operated exclusively for any or

all of the purposes for which this Corporation is organized.

Executed on the _____ day of _____, 1955.

ARTHUR J. MCCAREY, M.D.
E. L. BERNHART, M.D.
H. KENT TENNEY, M.D.

State of Wisconsin—County of Dane—ss.

Personally came before me this _____ day of _____, 1955, the above named Arthur J. McCarey, M.D., E. L. Bernhart, M.D., and H. Kent Tenney, M. D., to me known to be the persons who executed the foregoing instrument, and acknowledged the same.

_____
Notary Public, Dane County, Wisconsin.
My commission expires: _____

BY-LAWS

ARTICLE I

Identification

SECTION 1. *Name.* The name of the Corporation is "Charitable, Educational, and Scientific Foundation Incorporated of the State Medical Society of Wisconsin."

SECTION 2. *Registered Agent.*

Clause (a) *Obligation to Maintain.* The Corporation shall have and continuously maintain in the State of Wisconsin a registered agent, which agent may be either an individual resident in the State of Wisconsin, or a domestic corporation, or a foreign corporation authorized to transact business in the State of Wisconsin.

Clause (b) *Change of Registered Agent.* The Corporation may change its registered agent upon filing in the office of the Secretary of State of the State of Wisconsin a statement setting forth the facts required by law and executed by the Corporation by its president, or a vice-president, and verified by him, the corporate seal thereto affixed, and delivered to the Secretary of State.

SECTION 3. *Seal.* The seal of the Corporation shall have inscribed thereon its name, the fact of its incorporation in Wisconsin, and the words "Corporate Seal."

SECTION 4. *Fiscal Year.* The fiscal year of the Corporation shall begin on the first day of July in each calendar year, and end on the thirtieth day of June of each calendar year.

ARTICLE II

Board of Trustees

SECTION 1. *Number and Qualification.* The affairs of the Corporation shall be under the direction of a Board of Trustees. The number of trustees composing the original Board shall be three.

From and after the first annual meeting of trustees, the trustees shall be composed of the councilors and officers of the State Medical Society of Wisconsin and one elected representative of each component county or multi-county medical society which holds a charter from the State Medical Society of Wisconsin, provided the component society has elected such representative. Failure of the component society to elect such representative by the first annual meeting of trustees shall not preclude a later election by the component county society.

In addition, the Council of the State Medical Society of Wisconsin may from time to time elect, as trustees, additional persons who are not members of the State Medical Society of Wisconsin, provided the number of such trustees shall not at any time exceed 10.

SECTION 2. *Term.* Members of the original Board of Trustees shall hold office until the first annual meeting of trustees.

The terms of trustees who are councilors and officers of the State Medical Society of Wisconsin shall coincide with their terms as such councilors and officers of the State Medical Society of Wisconsin.

The elected representatives, qualified as of the date of the first annual meeting, of component county societies of the first, seventh, and ninth councilor districts of the State Medical Society of Wisconsin shall hold office until the second annual meeting. The elected representatives, qualified as of the date of the first annual meeting, of component county societies of the second, fifth, tenth, and thirteenth councilor districts of the State Medical Society of Wisconsin shall hold office until the third annual meeting. The elected representatives, qualified as of the date of the first annual meeting, of component county societies of the third, fourth, sixth, eighth, eleventh, and twelfth councilor districts of the State Medical Society of Wisconsin shall hold office until the fourth annual meeting.

The initial terms of the elected representatives of component county societies, who were not qualified as of the first annual meeting, shall expire at the time they would have expired had they been qualified as of the first annual meeting.

The initial terms of trustees, who are not members of the State Medical Society of Wisconsin, shall be fixed by the Board of Trustees at the time of their qualification, in such a manner as to result, as nearly as possible, in the expiration of one-third of the terms of all trustees annually.

For all except such initial terms, the terms of trustees shall be three years.

SECTION 3. *Vacancy.* Any vacancy occurring in the Board of Trustees from among the elected representatives of component county societies which had previously elected a representative may be filled by a majority vote at a meeting of trustees from among the membership of the particular component county society. Failure of a component county society to initially elect a representative shall not be deemed a vacancy.

SECTION 4. *Removal.* Any individual trustee may be removed from office by the Council of the State Medical Society of Wisconsin without assigning any cause. In case any one or more of the trustees are so removed, the Council of the State Medical Society of Wisconsin may at such meeting fill any or all of the trusteeships for the unexpired term of the trustee or trustees so removed, provided that in cases of elected representatives of component county societies, such trusteeship shall be filled from among the membership of such component county society. Failure to fill the unexpired term of the trustee so removed shall be deemed to create a vacancy or vacancies in the Board of Trustees.

SECTION 5. *Meetings.*

Clause (a) *Place of Meetings.* Meetings of the Board of Trustees of the Corporation,

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(Continued from page 461)

annual or special, may be held either within or without the State of Wisconsin.

Clause (b) *Time and Notice of Meetings.* The first annual meeting of the Board of Trustees shall be held at a time fixed by the Council of the State Medical Society of Wisconsin. The date of subsequent annual meetings shall be fixed by the Board of Trustees. Other meetings may be held throughout the Corporation fiscal year as may be decided by the trustees.

Meetings shall be held on notice by letter or telegram, delivered for transmission not later than the tenth day immediately preceding the day for such meeting. Notice of any meeting of the Board of Trustees may be waived in writing, signed by the person or persons entitled to such notice, whether before or after the time stated therein, and shall be equivalent to the giving of such notice. Attendance of a trustee at a meeting shall constitute a waiver of notice of such meeting, except where a trustee attends said meeting and objects thereat to the transaction of any business because such meeting is not lawfully convened. Neither the business to be transacted at, nor the purpose of, any meeting of the Board of Trustees need be specified in the notice or waiver of notice of such meeting.

Clause (c) *Quorum.* Twenty-five per cent of the number of trustees qualified at the time of any meeting, shall constitute a quorum for the transaction of affairs and business of the Corporation. The act of the majority of the trustees present at a meeting at which a quorum is present shall be the act of the Board of Trustees, unless the act of a greater proportion is required by the Articles of Incorporation or these By-Laws.

SECTION *6. Committees of the Board.* The Board of Trustees by resolution, adopted by a majority of the number of trustees fixed in these By-Laws, may designate one or more committees, each committee to consist of three (3) or more trustees elected by the Board of Trustees, which, to the extent provided in said resolution, shall have and may exercise, when the Board of Trustees is not in session, the powers of the Board of Trustees in the management of the affairs of the Corporation, except action in respect to election of officers or the filling of vacancies in the Board of Directors or committees created pursuant to the authority granted in this section.

SECTION *7. Non-Executive Committees.* The Board of Trustees by resolution, adopted by a majority of the number of trustees fixed in these By-Laws, may designate one or more committees, other than committees of the Board, for purposes designated in such resolution. The number of persons to serve on such committees shall be fixed by the resolution of the Board of Trustees.

ARTICLE III

Officers

SECTION *1. Number.* The officers of the Corporation shall consist of a president, a vice-president, a secretary, and a treasurer. Such subordinate officers as may be deemed necessary may be elected or appointed by the Board or chosen in such other manner as may be prescribed by these By-Laws.

SECTION *2. Qualification: Election and Term.* All officers shall be trustees, and the secretary shall be the secretary of the State Medical Society of Wisconsin. The principal officers shall be chosen annually by the Board at its annual meeting. Each such officer shall hold office until his successor is chosen and qualified, until his death, until he shall have resigned, or until he shall have been removed in the manner provided in these By-Laws, whichever shall first occur.

SECTION *3. Vacancies.* Whenever any vacancy shall occur in any office by death, resignation, or otherwise, the same shall be filled by the Board of Trustees, and the officer so elected shall be elected for the unexpired term of his predecessor in office and until his successor is chosen and qualified.

SECTION *4. Duties of Officers.*

Clause (a) *The President.* The president shall preside at all meetings of the Board and shall perform such other duties as usually pertain to this office.

Clause (b) *Vice-President.* The vice-president shall have such powers and perform such duties as the Board of Trustees may from time to time prescribe, or as the president from time to time may delegate to him. In case of the death of the president, or in case of his absence or inability to act, the vice-president shall perform the duties of the president.

Clause (c) *Secretary.* The secretary shall keep, or cause to be kept, in books provided for the purpose, the minutes of the meetings of the Board; shall see that all notices are duly given in accordance with the provisions of the By-Laws, and as required by law; shall be custodian of the records; and, in general, shall perform all duties incident to the office of secretary, and such other duties as may be assigned to him by the Board or by the president.

Clause (d) *Treasurer.* The treasurer shall be the financial officer of the Corporation. He shall have charge and custody of, and be responsible for, all funds of the Corporation and deposit all such funds in the name of the Corporation in such banks, trust companies, or other depositories as shall be selected by the Board; shall receive, and give receipts for, moneys due and payable to the Corporation from any source whatsoever; and in general shall perform all duties incident to the office of treasurer, and such other duties as from time to time may be assigned to him by the Board or by the president.

He shall, if required so to do by the Board, give the Corporation a bond in such amount and with such surety or sureties as may be ordered by the Board, for the faithful performance of the duties of his office and for the restoration to the Corporation, in case of his death, resignation, retirement or removal from office, of all books, papers, vouchers, moneys, and other property of whatever kind in his possession or under his control belonging to the Corporation.

ARTICLE IV

Amendments

These By-Laws may be amended by the Board of Trustees.

If the By-Laws are approved, immediate action will be taken to incorporate the Foundation in the

general manner outlined. As the House is to determine the amount of annual contributions from active Society members over age 35, the following resolution should be considered:

> "*Resolved*, That each active member of the State Medical Society of Wisconsin, age 35 and over, contribute on a voluntary basis the sum of $_____ to the Charitable, Educational, and Scientific Foundation, Inc. of the State Medical Society of Wisconsin."

A.M.A. Delegates

During 1954 the Society's membership increased sufficiently to permit an additional delegate to the American Medical Association. The Council has acted to name Dr. Joseph C. Griffith of Milwaukee to fill such vacancy and has designated Dr. E. L. Bernhart of Milwaukee, president-elect, as an alternate to Dr. D. H. Witte to replace Doctor Griffith. Dr. R. E. Galasinski of Milwaukee will serve as alternate to Doctor Griffith.

The Council suggests that, with four delegates to the A.M.A., the tradition can well be established that the president-elect of the Society be designated as an alternate delegate to the A.M.A. This will facilitate his attendance, provide him with experience in the affairs of that organization, and should assist in a closer liaison with its activities.

Other matters of a more routine character have been under Council supervision during the course of the year, and others may be reported as a result of the Council meeting just prior to the first session of the House.

REPORT ON NECROLOGY

The Council reports with sorrow the deaths of the following physicians since the last Annual Meeting. Members of the Society are indicated by boldface type.

E. P. Andrews, Portage
Willard E. Archer, Anoka, Minnesota
John S. Barnes, Albuquerque, New Mexico
D. H. Bruns, Milwaukee
T. J. Buckley, North Freedom
Jean M. Cooke, Darlington
John A. Enright, Milwaukee
Frank A. Everhard, Ripon
F. L. Fancher, Racine
Frank P. Foley, Dorchester
Walter F. Gager, Rhinelander
J. G. Garland, Milwaukee
W. B. Gnagi, Monroe
William J. Hanley, Milwaukee
John W. Harris, Madison
E. R. Hering, Shell Lake
W. W. Hume, Milwaukee
Fred E. Kosanke, Watertown
C. C. Newman, Wausau
L. N. Reis, Madison
Fred W. Riehl, Milwaukee
J. C. Sargent, Milwaukee
Alexander Schlapik, Miami Beach, Florida
Henry F. Schroeder, Marinette
A. A. Skemp, La Crosse
L. D. Smith, Milwaukee
J. W. Tanner, Eau Claire
E. M. Tillson, Milwaukee
C. E. Zellmer, Antigo

Supplementary Report of the Council

"Guiding Principles of Occupational Medicine"

Secretary Crownhart reported that, as a result of action taken by the Council at its meeting on May 1, copies of the "Guiding Principles of Occupational Medicine," as endorsed by the American Medical Association, had been distributed to the delegates. Both the Committee on Industrial Health and the general Council of the State Society had approved these Principles. The A.M.A. had requested endorsement by the House of Delegates.

Interprofessional Code

The Interprofessional Code, which was submitted in draft form to the House of Delegates in October, 1954, had received final action by the Wisconsin Bar Association. Under direction of the House, the Committee on Grievances and the Council had completed their study, and the Code had been approved.

During the course of this year, arrangements will be completed to send the Code to all members of the Wisconsin Bar Association and the State Medical Society of Wisconsin, but probably more important are plans to provide it to upper-class students in the law and medical schools of this state and to physicians and attorneys newly entering their professions.

It must be recognized, of course, that there may be modifications and revisions suggested in the future; but the Council believed this to be an important step in the development of mutual understanding on matters of mutual concern to the two professions.

Physicians and the Social Security Act

There had been much misunderstanding concerning the position of the American Medical Association with reference to the compulsory inclusion of physicians under the Social Security Act.

The A.M.A. had taken a position in opposition to compulsory inclusion but had also taken the position that it would not oppose legislation permitting physicians, as a matter of choice, to come in under the provisions of that law.

The Council believed that adoption of a resolution in support of the position of the A.M.A. was in order and submitted the following resolution for consideration of the House:

Resolution

WHEREAS, Titie II of the Social Security Act, as amended in 1954, extended the principle of compulsory contribution by the self-employed to Social Security funds with certain exceptions, including physicians; and

WHEREAS, Efforts have continued and so-called "polls" are being conducted by public officials and others in various areas of the country which are apparently designed to bring the medical profession under the Social Security Act on a compulsory basis, and the so-called "ballots" offered in the course of conducting such polls are frequently nonobjectively devised and unfairly worded; and

WHEREAS, There have been reintroduced into the 1955 session of the Congress the Jenkins–Keogh bills, which provide for development of a voluntary retirement program on the part of the self-employed, although, as phrased, these and related bills would

permit the self-employed to deduct only a fraction of the retirement benefits annually, which is permitted in private plans, and, it may be noted in passing, that the U. S. Treasury has approved many thousands of private plans recognizing deductions for individual retirement benefits equal to or greatly in excess of those in the Jenkins–Keogh bills, while it is reported thus far to have opposed passage of the Jenkins–Keogh bills or similar legislation; now, therefore,

BE IT RESOLVED, That this House of Delegates adopt as its position that of the American Medical Association in opposition to the compulsory coverage of physicians under the old age and survivorship provisions of the Social Security Act; and be it further

RESOLVED, That this House of Delegates also adopt as its position that of the American Medical Association of nonopposition to the voluntary coverage of physicians under the Social Security system; and be it further

RESOLVED, That this House express its support and endorsement of the Jenkins–Keogh bills, which recognize the principle of the income tax deferment of the annual cost of a modest, voluntary retirement program for the self-employed; and be it finally

RESOLVED, That physicians in Wisconsin and elsewhere in this country be urged to stand united in following the leadership of the American Medical Association in social security and voluntary pension matters in view of its long and careful study of those subjects, to the extent that the views expressed by that leadership coincide with their convictions or in cases in which physicians have no special knowledge of the subjects, fully recognizing, however, the fundamental right of any physician to hold and express contrary views.

New Councilor

Councilors and officers were saddened by the death, in an automobile accident, of one of their members—Dr. C. E. Zellmer of Antigo, whose term as a councilor would have expired in 1956. Acting under appropriate provision of the By-Laws, William P. Curran, M. D., of Antigo, was appointed to serve the balance of the term.

Elections

H. Kent Tenney, M. D., of Madison, was elected assistant treasurer of the Society; and T. W. Tormey, Jr., M. D., Madison, was elected general chairman of the Commission on State Departments. The following physicians were re-elected chairmen of the Commission's nine divisions:

H. A. Anderson, M. D., Stevens Point, Division on Tuberculosis and Chest Diseases

R. F. Purtell, M. D., Milwaukee, Division on Maternal and Child Welfare

Maxine Bennett, M. D., Madison, Division on Visual and Hearing Defects

H. A. Sincock, M. D., Superior, Division on Crippled Children

E. H. Pawsat, M. D., Fond du Lac, Division on School Health

Ray Piaskoski, M. D., Wood, Division on Rehabilitation

A. M. Hutter, M. D., Fond du Lac, Division on Geriatrics

H. W. Carey, M. D., Lancaster, Division on Public Assistance

E. D. Schwade, M. D., Milwaukee, Division on Nervous and Mental Diseases.

Doctor Cahana Honorary Member

Upon nomination of the Medical Society of Milwaukee County, the Council, by unanimous vote, and in recognition of his long services in the interest of public health of this state, elected Dr. Stephen Cahana of Milwaukee as an honorary member, which classification he also holds in the county society.

Blue Cross Physicians Approved

Other action taken was to approve the election by their hospital staffs of Drs. E. J. Nordby, Madison, and Bernard Kulkoski, Green Bay, as physician members of the Blue Cross corporation.

Marquette Anniversary

Finally, the Council directed the attention of the House to the fact that Marquette University is celebrating its 75th anniversary this year, and that doubtless the House would wish to take official recognition of that fact.

REPORTS OF COUNCIL COMMITTEES

COMMITTEE ON BLOOD BANKS

W. D. Stovall, chairman; T. J. Greenwalt; C. N. Neupert; and Paul Mason.

Recommendation

County medical societies should give full support to local public health officials in carrying out the 1955 polio vaccine program.

The state-wide polio vaccine program for 1955 was developed by the state health officer in cooperation with this committee and state education officials. District and local public health personnel will direct the program. Local physicians will administer the vaccine to the children. In counties where no public health nurse is available, the county medical society will assume responsibility for the entire operation.

Plans are under way for the development of a national blood program with the A.M.A. taking a leading role in negotiations. County medical societies, whether participating in Red Cross programs or locally operated plans, will need to follow development of this program very closely so that, when the appropriate time comes, they will be ready to find their proper place in the over-all program. Marked interest has been displayed by many groups during this period of change. Views and proposals of many of these organizations should be reviewed fully and studied in light of local needs, as well as area and national problems.

COMMITTEE ON CIVIL DEFENSE

M. J. Musser, chairman; E. P. Ludwig; K. E. Lemmer; J. S. Wier; and E. A. Bachhuber.

Recommendations

1. County medical society officers should give all possible assistance and advice to Mr. Theodore Noe, assistant co-director of health services in civil defense, when he visits areas in which physicians are needed for mobile medical teams.

2. Physicians assigned by county medical societies as captains of mobile medical teams should serve terms of at least three years so as to provide continuity to the civil defense effort in the medical field.

Serving as an advisory committee to the state health officer, who is co-director of health services in civil defense, the committee has assisted in the preparation of detailed plans for first aid, transportation, and hospitalization of casualties resulting from enemy attack on Wisconsin cities. The outlook for increased physician participation in civil defense has improved vastly since the state Office of Civil Defense has assigned Mr. Noe to devote full time to the development of mobile medical teams and other health aspects of the state program.

Federal agencies, with support of high public officials, have been giving increased emphasis to civil defense, and this is bound to be reflected in greater interest on the part of the public. Physicians should respond equally in their support of medical aspects of civil defense programs.

COMMITTEE ON MILITARY MEDICAL SERVICE

F. L. Weston, chairman; M. J. Musser; J. M. Sullivan; M. H. Steen; and O. G. Moland.

Recommendations

1. The committee should be continued as a means of providing the Wisconsin Advisory Committee to Selective Service with detailed information and advice on the availability and essentiality of Wisconsin physicians.

2. Assuming a continued need for physicians in the armed forces, the American Medical Association should be encouraged to seek establishment of a more uniform national pattern for the call up of physicians. Such a pattern might end the discouraging vagaries of present policies, restore better balance to medical education and research, and offer the individual physician an opportunity for long-range planning. The committee suggests that at the next annual meeting of the A.M.A., the Wisconsin delegates introduce a resolution which seeks to accomplish this purpose.

Since October, 1954, about 40 Wisconsin physicians have been commissioned for active military duty through Selective Service channels; and at least an equal number have voluntarily sought commissions in anticipation of Selective Service calls. The present "Doctor Draft" Law is scheduled to expire on July 1, 1955; but some means of providing physicians for the armed services is certain to replace it. Extensive active files continue to be a necessity in processing routine recommendations to Selective Service and in answering a large volume of inquiries from physicians and hospitals.

WISCONSIN VETERANS MEDICAL SERVICE AGENCY OPERATING COMMITTEE

J. S. Supernaw, chairman; O. A. Dittmer; Maurice Hardgrove; W. A. Fischer; and C. E. Koepp.

Recommendation

The Hoover Commission report on federal medical services released February 28, 1955, recommends increased out-patient treatment of veterans for both service-connected and non-service-connected disabilities. This report and its implications on the Home-Town Care Program should be carefully studied by all physicians.

The Wisconsin Home-Town Care Program for veterans with service-connected disabilities is in its ninth year of operation through the State Medical Society. Home-town care of veterans is limited primarily to home and office calls and laboratory procedures. Only emergency cases are approved for local hospitalization.

Authorizations received from the Veterans Administration for home-town care in 1954 totaled $143,215.53. In the previous year, 1953, such authorizations totaled $157,228.35.

From the time of its inception to February 28, 1955, the program resulted in the payment of $1,532,984.77 to physicians for services rendered to eligible veterans.

WISCONSIN VETERANS MEDICAL SERVICE AGENCY

CERTIFIED FINANCIAL STATEMENT
June 30, 1954

ASSETS		
Current Assets		
Cash in Bank—Administrative Fund	$ 4,875.97	
Cash in Bank—Medical Fund	2,858.03	
Medical Claims Filed with Veterans Administration	7,825.72	
Administrative Claims Filed with Veterans Administration	1,771.83	
Unfiled Administrative Claims	299.95	
Total Current Assets		$17,631.50
Fixed Assets		
Office Furniture and Fixtures	$ 2,434.17	
Less: Accumulated Depreciation	1,581.97	
Total Fixed Assets		852.20
Total Assets		$18,483.70
LIABILITIES		
Current Liabilities		
Due Doctors on Claims Filed	$10,683.75	
Due State Medical Society of Wisconsin	299.95	
Total Liabilities		10,983.70
Advance from State Medical Society of Wisconsin		
Balance of Cash Advance—June 30, 1954		$ 7,500.00

Certificate

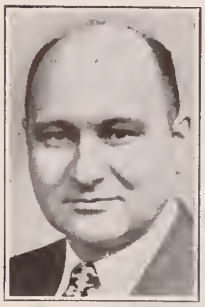
I have audited the accounts of the Wisconsin Veterans Medical Service Agency, a division of the State Medical Society of Wisconsin, Madison, Wisconsin, for the period January 1, 1954, to June 30, 1954, and

I hereby certify that, in my opinion, the above Financial Statement fairly presents the financial condition of the agency on June 30, 1954, and the result of its operations for the period January 1, 1954, to June 30, 1954, in conformity with generally accepted accounting principles.

/s/ Donald E. Gill
Certified Public Accountant

Madison, Wisconsin
October 30, 1954

COMMISSION ON PREPAID PLANS



E. M. Dessloch, chairman; Robert Krohn, vice-chairman; N. A. Hill, treasurer; John T. Sprague, assistant treasurer; H. E. Kasten; W. T. Casper; R. E. Garrison; K. H. Doege; Milton Finn; J. S. Supernaw; H. A. Aageson; R. M. Moore; C. G. Reznichek; Richard Foregger; G. W. Carlson; P. B. Mason; Arthur J. McCarey, president of the Society; and E. L. Bernhart, president-elect.

Wisconsin Physicians Service, the Blue Shield plan of the State Medical Society, is reaching out to meet the problems of health insurance protection not now fully met by the basic program with which physicians are familiar.

Two elements of insurance planning are involved: (1) a deductible feature; and (2) a comprehensive benefit program offering, in addition to current basic benefits, protection for expenses of diagnosis, first-day surgical and medical care of the newborn, home and office medical care, therapeutic x-ray and dental surgery. These proposals have commanded a considerable effort of the Commission and the staff in recent months.

The Commission has discovered that, contrary to popular expressions hailing them as virtual panaceas, neither can be simply applied within the structure and concept of Blue Shield in Wisconsin.

As to the first, the Commission desires to illustrate the complexity of creating a deductible program in Blue Shield.

> A "straight deductible" plan eliminates the full-payment opportunity for the subscriber.
>
> A "deductible item" contract which excludes benefits for specific procedures deprives the subscriber of insurance protection for important items of health care.
>
> A plan which guarantees the physician payment of the deductible amount if the subscriber fails to pay within a certain time limit would soon remove any incentive for the subscriber to pay.
>
> Paying the physician the full amount and billing the subscriber for the deductible would require costly collection methods which would destroy the effect of the deductible.

To date, the Commission has discovered only one method of instituting a deductible while preserving and protecting the service concept of full payment. This involves a mechanism by which Wisconsin Physicians Service pays the physician the full benefit for services rendered. Wisconsin Physicians Service then bills the employer for all deductible amounts incurred by covered employees during each month. The employer will reimburse Wisconsin Physicians Service and in turn collect the deductible amount from the employees. Of course, the program applies only to group coverage. One such group is already in effect in the state.

For the present at least, any other means of offering deductible-type surgical-medical contracts will need to be done through the identity of Physicians Indemnity Plan, a wholly indemnity plan operated under direction of the Commission for special situations which do not provide full payment in any respect.

As for a Blue Shield plan offering broader benefits, the Commission has conducted extensive research leading to the creation of a "Special Services Contract" which might be purchased by groups in addition to their basic Blue Shield benefits. The "Special Services Contract" probably will include benefits for x-ray therapy, first-day medical and surgical care for the newborn, and dental surgery on a full-payment basis. The subscriber would have the option of purchasing additional benefits for diagnostic x-ray and laboratory procedures and home and office medical care on an indemnity basis. The latter optional benefits would also be available to holders of basic Blue Shield protection who do not take the "Special Services Contract."

In 1954, the growth pattern of Wisconsin Physicians Service remained fairly stable. Coverage was increased by something just short of 2,000 contracts. The Blue Shield contracts in effect as of December 31, 1954, show 96,229 (80%) as group contracts; 2,407 (2%) as group direct pay; 13,598 (11%) as group conversion; and 8,082 (7%) as non-group. Family contracts total 73,187. There were 47,129 single contracts. Schedule "B" coverage is provided on 72,874 contracts and Schedule "A" protection on 47,442 contracts. The total number of persons covered by Blue Shield contracts is nearly 300,000.

Continuing emphasis is being given to enrolling individuals and small groups as the Commission believes this to be a fertile potential. The pilot program in non-group enrollment in Northwest Wisconsin is proceeding slowly. Progress is being made toward development of a series of public conferences on health insurance under the sponsorship of the University of Wisconsin. The reinsurance contracts for Major Illness Expense Insurance have been negotiated with two well-established private carriers in Wisconsin and are now in effect.

The volume of claims handled by the Claims Department continues to increase. During 1954, the department handled 72,930 cases, or an average of 6,100 per month. The Claims Committee of the Commission meets regularly to handle unusual cases, review claims procedures, and conduct special studies.

Statistical studies show that in 1953 a total of $3,014,217.55 was paid in claims. In 1954, the total claims paid increased to $3,079,500. Of the total dollar volume of claims paid in 1954, 44.5 per cent was paid under the "A" Schedule, and 55.5 per cent under the "B" Schedule. During the same year, $2,340,500 was paid to participating physicians (76%) and $739,000 was paid to subscribers (24%).

WISCONSIN PHYSICIANS SERVICE
Total Claims Paid 1954

OUT-OF-STATE PHYSICIANS . . $175,274.35

TOTAL OF ALL CLAIMS $3,079,558.90

NOTE: Payments are related to the county in which the physician practices and not to the location of the contract holder

WISCONSIN PHYSICIANS SERVICE
CLAIMS PAID
1954

	Number of Procedures	% of Total	Amount	% of Total	Average Cost Per Procedure
Surgery in Hospital	35,809	43.2	$1,702,800	55.3	$47.55
Surgery—Home or Office	12,170	14.7	149,300	4.8	12.27
Obstetrical	7,117	8.6	461,800	15.0	64.89
Medical (148,009 Days)	17,637	21.3	623,500	20.2	35.35
Anesthesia	5,546	6.7	106,300	3.5	19.17
X-ray	4,573	5.5	35,800	1.2	7.83
Totals	82,852	100.0	$3,079,500	100.0	$37.17

An analysis of the number of procedures and total dollar value of procedures paid in 1954 is shown above. It will be noted that medical care accounts for 20 per cent of the total volume of claims paid.

Physicians will be interested in the following map showing the amount of benefits during 1954 by county. These payments are related to the county in which the physician practices and not to the location of the contract holder, a fact which might influence the high amounts shown in several medical center areas.

WISCONSIN PHYSICIANS SERVICE
Madison, Wisconsin
BALANCE SHEET
December 31, 1954

Assets

Cash on Hand and in Banks		$ 790,744.81
Due from Agent		88,467.00
Refunds Receivable		2,747.00
Accounts Receivable		10,983.42
U. S. Government Bonds—Net	$1,666,524.75	
Accrued Interest Income	2,726.56	1,669,251.31
Office Furniture and Fixtures—Net		16,291.15
Prepaid Reinsurance		750.00
Deferred Charges		707.75
Total Assets		$2,579,942.44

Liabilities and Reserves

Accounts Payable		$ 18,926.67
Merit Rating Credits Payable		3,741.56
Physicians Claims Payable		396,288.35
Reserve for Old Outstanding Checks		3,045.00
Unearned Income		390,043.67
Reserves—Maternity Benefits	$ 203,700.00	
Disaster Claims	271,009.00	
Major Illness Expense	100,000.00	
Unforeseen Contingencies	570,968.20	
Administrative	554,587.33	
Investment	67,632.66	1,767,897.19
Total Liabilities and Reserves		$2,579,942.44

WISCONSIN PHYSICIANS SERVICE
Madison, Wisconsin
COMPARATIVE STATEMENT OF INCOME AND EXPENDITURES
For the periods January 1 to December 31, 1953 and 1954

	1-1-54 to 12-31-54	1-1-53 to 12-31-53	Increase or (Decrease)
Income			
Earned Premium Income	$4,164,568.07	$3,910,994.72	$253,573.35
Other Administrative Income	9,729.39	781.89	8,947.50
Investment Income	29,242.62	17,664.62	11,578.00
Total Income	$4,203,540.08	$3,929,441.23	$274,098.85
Expenditures			
Benefits Incurred	$3,136,755.40	$2,983,567.05	$153,188.35
Expenses of Agent	302,352.26	345,429.98	(43,077.72)
Salaries	125,046.93	113,436.15	11,610.78
Legal Expense	11,798.01	8,413.54	3,384.47
Auditing Expense	9,257.90	9,617.72	(359.82)
Actuarial Expense	12,419.34	8,060.80	4,358.54
Conference Expense	14,992.83	12,962.76	2,030.07
Staff Travel	7,832.02	6,594.48	1,237.54
Stationery and Supplies	6,682.55	11,077.60	(4,395.05)
I.B.M. Expense	12,361.17	8,793.42	3,567.75
Rent	11,167.00	9,900.00	1,267.00
Office Expense	3,224.12	2,234.92	989.20
Postage and Express	4,453.59	4,731.39	(277.80)
Payroll Taxes	3,679.22	3,057.79	621.43
Telephone and Telegraph	3,427.72	4,922.28	(1,494.56)
Employees' Group Insurance	1,660.21	1,603.54	56.67
Depreciation	2,620.98	2,956.83	(335.85)
Insurance	667.21	589.40	77.81
Association Dues	4,253.42	3,467.92	785.50
Conservation and Promotion	19,357.33	----------	19,357.33
Other Administrative Expenses	6,554.29	2,731.46	3,822.83
Total Expenditures	$3,700,563.50	$3,544,149.03	$156,414.47
Available for Reserves	$ 502,976.58	$ 385,292.20	$117,684.38
Distribution of Each $100.00 of Income			
Benefits Incurred	$ 74.62	$ 75.93	$(1.31)
Expenses of Agent	7.19	8.79	(1.60)
Other Adminis. Expenses	6.22	5.47	.75
Additions to Reserves			
Service Benefit Reserves	6.56	5.63	.93
Administrative Reserve	4.71	3.73	.98
Investment Reserve	.70	.45	.25
	$ 100.00	$ 100.00	$ ---------

Eight large insurance companies continue to participate in the Wisconsin Plan. These companies submitted a considerable volume of cases for review during the past year. Each participating plan reimburses the Society for expenses incurred by it for such services as reviewing policies and assisting the companies in determining their full liability on claims.

THE COMMISSION ON STATE DEPARTMENTS

T. W. Tormey, Jr., chairman; H. A. Anderson; R. F. Purtell; Maxine Bennett; R. G. Piaskoski; A. M. Hutter; E. H. Pawsat; H. W. Carey; H. A. Sincock; and E. D. Schwade.

The wide variety and scope of projects currently under the direction of this Commission preclude anything but a progress report on the activities of most of its divisions during the past six months. Substantial accomplishments have been made in several areas, notably maternal and child welfare, nervous and mental diseases, and school health. The Commission seeks the guidance of the House of Delegates in anticipation of a full year in which to carry on its work before the next annual session.

DIVISION ON CRIPPLED CHILDREN

Henry A. Sincock, chairman; J. W. Nellen; D. W. McCormick; R. C. Waisman; M. G. Peterman; Kate P. Newcomb; F. D. Bernard; and A. B. Weinstein.

Progress Report

The division continues to advise the Bureau for Handicapped Children. There are approximately 60,000 handicapped children in Wisconsin under the age of 21 years. Nearly one-quarter of these have handicaps which can be met through programs of the bureau, and nearly 12,000 actually participate in these programs. A total of 36 orthopedic clinics were held in 1954. These clinics handled 1,912 children for a total of 2,297 examinations. Nearly 295 children were seen for the first time. County medical societies are urged to continue their cooperation in the orthopedic clinics.

The need for a regional rheumatic fever program continues to be evident, according to the bureau. Some of the more populous counties are urged to consider this as a special project. Reference is made to suggested procedures for the establishment of rheumatic fever programs which have been sent to all county medical societies.

DIVISION ON GERIATRICS

A. M. Hutter, chairman; M. T. Morrison; M. J. Musser; C. A. Olson; Owen Otto; George G. Stebbins; Millard Tufts; and R. H. Quade.

Progress Report

A guide for medical societies in the establishment of nursing homes is the major project in preparation. Topics to be included are: What is a nursing home? Is a nursing home needed? Where shall a nursing home be built? What kind of a building should it be? What is the relationship of the practicing physician to the nursing home as regards free choice by the patient?

The results of a study conducted in Dane County regarding the health needs, services, and facilities for the aging and long-term patients are being watched closely. The first portions of the report relating to the needs of Dane County in regard to the aged have already been published. When the full report is available, the division will study it with a view to determining whether the same pattern for survey and action should be recommended for the entire state or for county areas.

DIVISION ON MATERNAL AND CHILD WELFARE

Robert F. Purtell, chairman; E. A. Birge; T. V. Geppert; F. G. Johnson; G. S. Kilkenny; A. H. Stahmer; D. D. Willson; and J. D. Wilkinson.

Recommendations

1. When results of the current fetal-neonatal survey are available, they should be brought before hospital staffs and medical groups within the state in the same manner as the recently conducted maternal mortality study.
2. Prematurity institutes should be continued as the demand throughout the state might indicate.
3. The maternal mortality study should be continued as a one or two-year study is totally inadequate.

For the seven months' interim since the last meeting of the House of Delegates, this division submits the following report:

The Fetal-Neonatal Survey

Forty-seven hospitals and 17 teams of pediatricians, obstetricians, pathologists, and general practitioners are cooperating in a study of fetal-neonatal deaths in Wisconsin. This is a large-scale pilot survey. The various teams assigned to this study had not submitted their findings to this division at the time of publication.

From the statistical data and medical reports the division hopes to find improved methods of medical care and technics whereby more and more infants falling within this group will be saved.

Prematurity Institutes

A series of short intensive training programs on prematurity, as conducted in 1954, have been renewed at the Milwaukee Hospital Maternity Pavilion. These institutes have been tremendously popular and have done an immense amount of good. Nearly 25 hospital staffs have designated physicians and nurses to attend. They will be instructed in the "team" approach to care of prematures and in specific procedures which can be established within their local hospitals to provide better care for this type of patient.

Suggested Procedures for Care of Maternal and Pediatric Patients

The division is currently developing a guide or yardstick which will be available to all hospital staffs. This project is new and incomplete at this writing. When complete, hospital staffs will be urged to meet with their hospital boards or administrators to evaluate their own services in relation to recommendations of this division. Improvement in medical care in the nursery and delivery room adding to the safety of the infant and mother will be the primary objective of this project.

The Maternal Mortality Study

In October, 1952, the House of Delegates directed this division to conduct a maternal mortality survey. At the October, 1954, meeting, the results of the first year's study were reported to the delegates. During the past seven months volunteer speakers under the direction of this division have presented to hospital staffs and county medical society meetings the detailed results of this survey. The findings of the Maternal Mortality Study Committee leave no doubt that a serious need exists within various hospital staffs for improvement of basic requirements for good patient care in obstetrics and pediatrics. Improvement in medical care will come only with continued study and effort on the part of the profession as a whole. The division and the Maternal Mortality Study Committee are completely in favor of continuing the Maternal Mortality Survey and strongly recommend to the House of Delegates that this be done. It is the unanimous opinion of the division that a one or two-year study is totally inadequate. The division wishes to congratulate the medical profession within this state for its wholehearted cooperation in making this very worth-while study possible.

Anesthesia Survey

A study on obstetric anesthesia and analgesia is currently being made by the division. The results of this study are incomplete and will be reported to the delegates at a later date.

DIVISION ON NERVOUS AND MENTAL DISEASES

E. D. Schwade, chairman; Owen Clark; Roland Jefferson; Keith Keane; A. A. Lorenz; Leslie A. Osborn; J. T. Petersik; Horace K. Tenney, III; Henry Veit; Chester Wade; Charles Wunsch; and Walter Urben.

Subcommittee on Clinical Psychologists

E. D. Schwade, chairman; Saul Pollack; Hans Reese; and Chester Wade.

Subcommittee on Commitment Laws

Keith Keane, chairman; Walter Urben; J. T. Petersik; Owen Clark; Henry Veit; Roland Jefferson; Michael Kasak; and E. D. Schwade.

Subcommittee on the Disturbed Child

Horace K. Tenney, III, chairman; Sara Geiger; Owen Otto; Robert O'Connor; A. A. Lorenz; James Vedder; W. C. Lewis; L. M. Simonson; and E. D. Schwade.

Subcommittee on Medical Residencies

Chester Wade, chairman; H. H. Reese; H. K. Tenney; Keith Keane; William Bleckwenn; Leslie Osborn; William S. Middleton; and E. D. Schwade.

Subcommittee for Studies in Alcoholism

James R. Hurley, chairman.

Progress Report

The work of the Subcommittee on Commitment Laws during 1953 and 1954 is embodied in Bill 291, S., which is a major part of the Society's 1955 legislative program. This bill, if adopted as presented, will be a most significant step forward in the care of, and will provide for a more orderly medical and legal procedure for the detention, custody, and examination of, mentally diseased persons. The laws as they exist are archaic and outmoded in the face of modern medicine. Psychiatrists and other medical people are generally in favor of these changes. Consultations with the Department of Public Welfare, the State Judges' Association, state lawyers, and interested agencies have been obtained frequently. Within the framework of this bill the now outmoded use of the word, "epileptic," is to be deleted in the statutes, and this will be another significant step forward in the management of the epileptic. Wisconsin has led the nation in modernizing laws as they apply to the epileptic.

Among the projects in process or still to be developed are the following:

1. A plan to stimulate, co-ordinate, and help develop special facilities for the emotionally disturbed child in hospitals where pediatric and psychiatric services are available.

2. A manual for judges which will acquaint them with special procedures and facilities which would be better utilized for children with severe emotional disorders.

3. Special study concerning the treatment programs for disturbed children in all hospitals, but more especially at the northern and southern hospitals for exceptional children.

4. A manual for medical directors of county hospitals with application to mental disease.

5. A correlative and cooperative study on alcoholism.

6. Joint conference with a plan for stimulating a program for reading and special disabilities together with other committees in order that a program for detection of reading disabilities may reach into the rural areas.

7. Further conferences with psychologists in order to develop a better understanding of their wishes and to develop a better understanding of the relationship between psychiatric medicine and psychology.

8. Conferences and cooperation with the Mental Health Society in Wisconsin (at least two physicians are to be appointed through the Division of Nervous and Mental Diseases to work with the Board of the Wisconsin Mental Health Society, in an official or unofficial capacity).

DIVISION ON PUBLIC ASSISTANCE

H. W. Carey, chairman; C. M. Carney; C. A. Olson; L. F. Morneau; E. W. Schacht; and W. K. Simmons.

Progress Report

Federal and state governments are becoming increasingly concerned with rising costs of health care for welfare recipients. This interest is almost certain to produce a variety of legislative and administrative suggestions for changes in the method of providing medical care benefits to such persons. A state-wide fee schedule or a uniform system of determining and administering medical benefits is a possible proposal. Constant and careful study is needed. At the same time work is continuing with the State Department of Public Welfare and its Division of Public Assistance on the potentialities of a fee schedule which can be the basis of negotiation between welfare departments and county medical societies in Wisconsin.

DIVISION ON REHABILITATION

Ray Piaskoski, chairman; P. J. Collopy; E. P. Roemer; J. G. Beck; and C. C. Gascoigne.

Progress Report

Problems of medical consultation in district and local offices of the Rehabilitation Division of the State Board of Vocational and Adult Education are under study. Questions raised relate to terms of appointment and services of consultants and whether a county medical society should suggest names of prospective consultants.

Also being studied are provisions of recently approved federal legislation in the field of rehabilitation. The Vocational Rehabilitation Amendments of 1954 provide for increasing funds to state programs on a matching basis. Not only will support be given to the basic program undertaken in 1954, but the existing program will be extended and improved. Special projects will be undertaken to reach a greater proportion of Wisconsin individuals who might be eligible for medical and hospital services leading to their restoration.

The medical facilities Survey and Construction Act of 1954 amends the hospital survey and construction provisions of the Public Health Service Act to provide assistance to the states for surveying the need for diagnostic or treatment centers, for hospitals for the chronically ill and impaired, for rehabilitation facilities, and for nursing homes, and to provide assistance in the construction of such facilities through grants to public and non-profit agencies and for other purposes.

DIVISION ON SCHOOL HEALTH

E. H. Pawsat, chairman; A. C. Edwards; A. H. Heidner; W. R. Manz; F. J. Mellencamp; and J. R. Schroder.

Recommendations

1. Physicians are requested to give full support to the school health conferences tentatively scheduled for Superior and Whitewater during 1955. Attendance and participation of physicians is appreciated by school people, nurses, and parents.

2. A member of the county medical society should be appointed to serve on the local school health councils wherever these are established or anticipated.

3. Problems or misunderstandings as to medical regulations associated with the Wisconsin Interscholastic Athletic Association program should be brought to the attention of the Division on School Health.

4. County medical societies are urged to obtain copies of the bulletin, "School Health Examinations," recently reprinted with funds supplied by the State Board of Health. It is extremely valuable in formulating local school health programs.

5. Fields of study to be considered by the division, other than the further development of the school health conferences, are:

a. Review of training room practices in school athletic programs.

b. Sports participation by students at grade school and junior high school levels.

c. Development of school health programs in rural areas.

Two additional highly successful school health conferences have been of unusual significance, especially in terms of sound public relations for the medical profession. The conference at Stevens Point in October was attended by 225 persons, the Milwaukee conference in February by 800 persons. The meetings have given physicians the opportunity to define many medical problems which have too long and too often been misunderstood by school people, nurses, and parents.

Medical regulations of the Wisconsin Interscholastic Athletic Association are studied periodically by a special committee. This liaison has most certainly improved the program in both its insurance and athletic health aspects.

There is continued emphasis on the development of local school regulations requiring chest x-rays as part of the physical examination of all new employees, as well as part of the periodic re-examination of all school personnel.

DIVISION ON TUBERCULOSIS AND CHEST DISEASES

H. A. Anderson, chairman; Einar Daniels; Helen Dickie; D. A. Gutheil; F. B. Landis; L. W. Moody; G. C. Owen; A. A. Pleyte; and C. M. Yoran.

Recommendations

1. Physicians interested in securing reproductions of films taken of patients by the mobile units of the State Board of Health during the past year should make their requests to the State Board as soon as possible so that a true evaluation of the value of the service can be obtained. Such requests must be made for individual patients.

2. County medical societies and individual physicians are urged to correct misimpressions concerning drug therapy for tuberculosis which have caused the public to request treatment without institutional care.

Two years ago, at the suggestion of this division, the State Board of Health set up a service to supply physicians with reproductions of x-rays taken by the mobile units. To date the response has been most disappointing; and it is questionable whether the service can or should be continued at state expense unless greater use is made of it. Since February *The Wisconsin Medical Journal* has carried an illustrated announcement of this service. After an appropriate test period results will be evaluated.

Initial steps have been taken to screen all county and state mental institutions to determine the extent to which localized control programs are needed. Recommendations are being prepared regarding the need for a central treatment facility for all mentally ill patients suffering from tuberculosis.

Re-emphasis should be placed on the fact that the family physician should not be influenced by public pressures for ambulatory care of the tuberculous based on lay publications' glowing reports of new drugs. Ambulatory therapy is justified only after the contagious condition has been arrested and then only in carefully selected cases with constant and close medical supervision. Bed rest in an institution with specialized services is still recommended for all patients with active tuberculosis.

Improved treatment for tuberculosis has, nevertheless, markedly reduced bed occupancy in many county tuberculosis institutions. The determination of how best to use such facilities in the future requires close study and cooperation by the Society with the Sanatorium Trustees Association, the State Board of Health, and the Wisconsin Anti-Tuberculosis Association.

A suggestion that such facilities be adopted to meet the pressing geriatric needs of the state has significant potentialities and should be fully explored.

Continued cooperation is needed with the State Board of Health and the Division of Mental Hygiene of the State Department of Public Welfare on the orderly development of periodic examinations for all patients in county mental institutions, and the organization of proper isolation for active cases of tuberculosis until such time as a centralized, statewide institution for the tuberculous mentally ill can be provided.

DIVISION ON VISUAL AND HEARING DEFECTS

Maxine Bennett, chairman; John Doolittle; Howard High; E. G. Nadeau; William Randolph; C. G. Reznichek; S. B. Russell; and Edward Zeiss.

Recommendation

County medical society officers and other physicians in any way associated with school vision screening programs are urged to acquaint themselves with "An Outline to Facilitate the Development of a School Vision Screening Program." The outline explains development of a program which would permit the patient free choice of physician or optometrist but would not permit the optometrist to take an active part in the screening program itself within the school.

A recommended school vision screening program has been devised in cooperation with a committee of optometrists. The outline has been circulated to county medical society officers. Additional copies are available upon request.

Full cooperation is encouraged with the Bureau for Handicapped Children in expanding the school screening program to reveal hearing defects. Problems arising out of the services of otologic clinics may be filed with the division chairman so that they may be handled in an orderly fashion. Physicians confronted with patients losing their sight and in need of rehabilitation are encouraged to advise the patients to accept the help of the State Department of Public Assistance, Services to the Blind. With the patient's consent the physician should see that this agency of state government is informed so that a member of its staff can meet with the patient and start a program of rehabilitation and adjustment before complete loss of sight has resulted in withdrawal and resistance to help for rehabilitation.

Excerpts from Report of the President

President Arthur J. McCarey: It was only last autumn that we assembled here in Milwaukee for our 1954 Annual Meeting. Now it is May, and we meet again, to hold our 1955 meeting.

This change in the time of the Annual Meeting has made a lot of work for the staff, which has made the necessary arrangements, and for the Council on Scientific Work, which has had to supply another program so soon after the splendid program it gave us last October. But, as usual, this committee, to which we entrust one of the most important of our activities, came through with flying colors. I want to extend to it my thanks and congratulations on its accomplishments.

Our insurance program has been making good progress since last we met. You will remember that at our last meeting we were deeply concerned over the problem of the insurance of federal employees. I am happy to state that this issue, at least for the present, seems to have resolved itself in a satisfactory manner; and the impact of Wisconsin upon this question seems to have had quite a little to do with the way it was decided.

Wisconsin was host in the February just past to the tenth anniversary meeting of the Council on Rural Health of the American Medical Association. Many hundreds of people from all over the United States met here in Milwaukee to attend what, I was told in many letters that I have received since then, was a most successful meeting. The State Medical Society was of great help in arranging entertainment and in extending typical Wisconsin hospitality. It was brought home to me many times that health is the responsibility of all the people in a community and not only that of the medical profession and the ancillary health services.

Another high point in the activities of the State Medical Society was the holding, in January, of the first Interprofessional Institute in Madison. There came together people from all the various organizations, boards, associations, and societies to interest themselves in the health and welfare of Wisconsin citizens. I believe this was the first time such a meeting was ever held.

It was interesting to meet all these people and to hear them discuss their mutual problems. These institutes should be held regularly because by means of them much can be accomplished to coordinate health activities.

In May, 1954, the Council of this Society authorized the study of a proposal to create a Scientific, Educational, and Charitable Foundation. The Articles of Incorporation and By-Laws governing the organization of this corporation have been prepared and are ready for your approval.

In June of this year or thereabouts this Society's headquarters will move into its new building. Located on the shores of Lake Monona, with a magnificent view of the Capitol dome across the broad expanse of waters, it is a fitting tribute to the growth and development of this Society in the interest of the people of this state.

This building was made necessary mainly by the growth of Wisconsin Physicians Service, and at last our staff and assistant personnel will have a place to work in which their health and their efficiency

will not be jeopardized by the crowded conditions under which they have labored for the last three, four, or more years.

This new home was built for the purpose for which it was intended. It is a building that can well accommodate all of our activities, not only of the present but of the future. Every member of the State Medical Society, when he goes to Madison, should visit the new headquarters. The staff will be glad to see you and will make you welcome.

I want to thank the members of the House of Delegates, our councilors, the members of all the commissions and committees, and the general membership as well for the loyal support that they have given this organization during my term of office. I, too, have enjoyed their help and cooperation. Certainly I have needed their tolerance and understanding.

I want to thank Charlie, Roy and Tom, Earl and Paul, and all the other members of the staff and their assistants for their patience and for the many courtesies they have extended to me. I owe them all a debt of gratitude. And to Jean and Joan, the sweethearts of SMS, if you will, I want to say a special "thank you."

In closing, I want to make a special plea for a closer and more understanding relationship with our insurance program. Let us remember that this program was devised in the hope that the application of the insurance principle might be the logical method of meeting medical care costs, especially for the lower income groups, and that, with proper understanding and cooperation on the part of both patient and physician, medicine and society in general will be capable of solving this problem by voluntary means. Let us not be lulled into a false sense of security. Compulsory national health insurance is all ready to step in in case we fail. We have been accumulating experience. We are thinking along the lines of insuring not the first dollar but the last dollar of medical expense costs. The ideal of deductible insurance is occupying a large part of our thinking. Major illness insurance is already being written. Our Commission on Prepaid Plans is working long and diligently in the interest of a realistic program.

This being a democratic organization, constructive criticism is always welcome; but when the House of Delegates, after careful study and consideration, adopts a program, that program should be supported to the fullest extent possible by each and every one of us, until experience and further study suggest necessary changes.

The time that I have spent as president-elect and president has been very interesting indeed. Our Society concerns itself with many things. A careful study of them all convinces me that, in the interest of the medical profession and the people of our state, they are all necessary.

Our Society is fortunate in having so many of its members ready and willing to spend their time, at considerable sacrifice, to help their State Medical Society accomplish its many objectives.

Thank you for having given me the opportunity of serving my profession and my State Medical Society.

Report of Emergency Consultation Committee

President McCarey: Mr. Speaker, I desire to present to this House of Delegates the special report of the Emergency Consultation Committee, appointed by me to advise this Society.

Less than two weeks ago two Wisconsin physicians were notably recognized by an invitation to attend a special conference called by Mrs. Oveta Culp Hobby with reference to the Salk vaccine and its equitable distribution. Dr. W. B. Hildebrand of Neenah-Menasha, nationally recognized as a leader in the field of general practice, and Dr. Carl Neupert, our deservedly respected state health officer, were these invitees. At personal sacrifice, with short notice, and in full recognition of their Hippocratic Oath, these two physicians met with others to lend their invaluable advice.

Upon their return, each communicated to the State Medical Society the importance of the problem and the necessity (in their judgment) of prompt leadership. Acting upon their information, and after consultation with fellow members of my profession, I invited collaboration of various Wisconsin individuals in this matter.

I asked official representation from the governor's office, and from the state legislature and various other official bodies, including the State Departments of Nursing, Pharmacy, Medical Examiners, and Education. I asked Mr. John Tramburg of the State Department of Public Welfare; Mr. Francis Strapp, southern Wisconsin representative of the National Polio Foundation; and Dr. F. J. Mellencamp, chairman of the Wisconsin Academy of Pediatrics, to serve in an advisory capacity to this committee. Without hesitancy and in full recognition of these perplexing problems confronting the nation, these men and women, I am proud to report, accepted the task and willingly complied with my request.

I am proud of their service to the public. I am proud of the caliber of men who represent our State in public office, and of the private citizens who served with them.

I express my appreciation to them and consider it a privilege to present their report to you.

WHEREAS, Polio vaccine is in short supply; and

WHEREAS, There is a higher incidence of this disease in the age group of six months to 13 years and in pregnant women; and

WHEREAS, The National Foundation for Infantile Paralysis will provide vaccine for first and second grade children:

Our committee recommends that the distribution of available current supplies be limited to this group (six months to 13 years and pregnant women) in so far as they become available.

Further, it is recommended that as the vaccine becomes available, notice be given and the priority extended to include children from ages 14 through 19.

Because all polio vaccine coming into Wisconsin is certified as to safety, potency, and purity by the Biologics Control Laboratory of the National Institutes of Health of the U. S. Public Health Service prior to its licensing and release, the committee recommends that such vaccine be put to use as rapidly as available, without delay by the imposition of additional requirements as to safety, potency, and purity.

To assure that the vaccine is being administered to those entitled to it under the priority arrangement, and to assure that only the licensed vaccine is actually provided, the vaccine should be released only to licensed physicians through the normal commercial distribution channels.

The public should be reassured that appropriations by various localities of special funds to provide local citizens with free vaccine will not affect the equitable distribution according to the various priorities.

The committee recommends that the schools distribute educational information prepared by the State Medical Society of Wisconsin for the parents of all pupils in elementary schools on the problems of supply, distribution, and administration of the vaccine.

National Selective Service Grants Certificates of Appreciation

In a telephone conversation between Colonel Bentley S. Courtenay, state director of Selective Service, and Dr. F. L. Weston, chairman of the Wisconsin Advisory Committee to Selective Service, Colonel Courtenay made the following remarks before the House of Delegates: (Doctor Weston was confined to his bed in Madison due to a back injury and was unable to be present.)

Colonel Courtenay: I have a very pleasant duty to perform. I am appearing here in behalf of the Selective Service System for the purpose of awarding a certificate to the State Medical Society in appreciation of the notable service that the Society has provided to the Selective Service System over the last four years.

The system started in 1951, so we have had four years of experience with it. With the law about to expire and some question as to whether it will be renewed, I think that a very brief review of what has happened is in order.

We have inducted about 166 doctors from this state, and many more pass through our records as a consequence of their having accepted reserve commissions. We have inducted 80 dentists. The service that the State Medical Society provided in terms of manpower and support to the Advisory Committee, and the service that the Advisory Committee supplied to the state headquarters, the local boards, and the appeal boards, was invaluable and made the difference between success and failure without a doubt.

A large number of people played a part, and I believe that I would be remiss if I didn't mention some people besides yourself. I think we should mention the members of your Society's Committee on Military Medical Service. I believe we should mention Dr. Marc Musser of Madison, Dr. J. M. Sullivan of Milwaukee, Dr. Marvin Steen of Oshkosh, and Dr. O. G. Moland of Augusta, who represented the Medical Society and served as the hard core for the Selective Service Advisory Committee.

In addition to Doctor Weston there were Dr. Royal Mashek of the Dental Society, Dr. B. A. Beach of the veterinarians and Dr. Carl Neupert, representing public health. They are the professional people who did the work of the Advisory Committee.

Backing them up very ably, Mr. Charles Crownhart, Mr. Earl Thayer, and Mrs. Helen B. Supernaw all deserve our vote of thanks. I hope you will permit me to intrude the name of one of my staff into this little story, and mention the name of Major Curtis L. Shepard, to whom was delegated the entire responsibility with a minimum of supervision and direction from me, handling our side of the show at state headquarters.

In recognition of all of this work, and particularly in recognition of the services rendered by the Medical Society, I asked General Hershey to prepare a certificate which I should like to read and present to your president.

"This Certificate of Appreciation is hereby awarded to the State Medical Society of Wisconsin, in grateful recognition of valuable service contributed to the nation and to the Selective Service System in the administration of the Universal Military Training and Service Act. Awarded at Washington, District of Columbia, this 14th day of April, 1955. Signed, Lewis B. Hershey."

Added to that, in customary military form, is the Citation, which reads: "The State Medical Society of Wisconsin is hereby commended for the assistance it has rendered to the Wisconsin State Advisory Committee to Selective Service by furnishing the Wisconsin State Advisory Committee with the administrative personnel and facilities necessary to its operation; and by providing unreserved support for the Advisory Committee's actions, the Society has materially assisted in the administration of the Selective Service System."

This is a government of laws and not of men, but men administer the laws. Without people like Doctor Weston we wouldn't have had the kind of results that you and I have observed in these last four years.

It is no surprise to you gentlemen here—it was no surprise to me—to find Doctor Weston heading this thing and doing an extraordinary job. I will not embarrass him, in view of the fact that he is listening in, by eulogizing him. I will merely read the citation which accompanies a similar certificate addressed personally to him:

"Dr. Frank L. Weston is hereby commended for his leadership, integrity, and diligent service as chairman of the Wisconsin State Advisory Committee to Selective Service. His selfless public service has materially assisted in the administration of the Selective Service System. Issued this 14th day of April, 1955. Lewis B. Hershey."

That about ends it, except to add my own personal word of thanks. If the law is extended, I am sure of the fact that we will continue to do business in as graceful, as easy, and as effective a way as you and I have done business these last four years. I am certain that Wisconsin has an outstanding record in the administration of this law. I am sure you share with me an intention to keep it that way.

In closing, let me thank you for the unusual privilege of appearing before you again.

Doctor Weston: Colonel Courtenay, may I, for the State Medical Society, thank you for your very kind presentation, and may I thank you further for stating quite clearly that the services rendered to the Selective Service group have been rendered by the combined efforts of many in the Society, as well as their administrative aides in the central office.

This has not been a one-man job, and it is just a part of the Society, as always, trying to do some-

thing for the public good, with as little selfishness on its part as possible.

May I thank you again. Good night, all. (Applause) (End of telephone conversation).

Speaker Simenstad: Colonel Courtenay, on behalf of the State Medical Society, may I thank you very much for the citation and also for the very fine thing you have done for Doctor Weston. I am sure that he appreciates it very much. You may rest assured that in the future the State Medical Society of Wisconsin will always cooperate most fully with you and your department.

REPORT OF THE PRESIDENT-ELECT

The report of the president-elect, Dr. E. L. Bernhart of Milwaukee, was published in the June issue of *The Wisconsin Medical Journal.*

His committee appointments were published in the May Medical Forum section of the Journal. On motion of Dr. G. W. Carlson, Appleton, seconded by Dr. E. C. Cary, Reedsville, carried, the committee appointments were approved.

REPORT OF THE TREASURER

In the absence of Dr. F. L. Weston, treasurer, earlier reported, Secretary Crownhart presented the treasurer's report, which related only to those operations of the Society which are the direct responsibility of the treasurer.

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin
FINANCIAL STATEMENT
December 31, 1954

ASSETS		
Cash on Hand and in Banks		$ 12,313.57
Due from Divisions of State Medical Society—Current	$ 3,913.87	
Due from Student Loan Fund	312.50	
Accounts Receivable—Physicians, Employees and Others	6,635.40	
Guaranty Deposit	425.00	
Total Receivables		11,286.77
Working Capital Advances		
Wisconsin Medical Journal	$ 7,959.07	
Wisconsin Veterans Medical Service Agency	7,500.00	
Total Advances		15,459.07
Land—East Gorham Street		31,859.22
Office Building	$ 31,969.00	
Building Improvements	19,628.67	
Furniture and Equipment	33,356.27	
Total	$ 84,953.94	
Less: Accumulated Depreciation	29,631.22	
Total Depreciable Assets—Net		55,322.72
Prepaid Expenses and Deferred Charges		2,974.46
Total Assets		$129,215.81
LIABILITIES		
Vouchers Payable	$ 10,861.05	
Due American Medical Association	25.00	
Dues—Suspense	162.50	
Prepaid Membership Dues	1,458.00	
Prepaid Exhibit Space Rentals	4,767.75	
Prepaid Postgraduate Clinics	105.00	
Deferred Income	2,638.94	
Total Liabilities		20,018.24
NET WORTH		
Surplus—General Fund	$100,576.85	
Net Worth of Wisconsin Medical Journal	7,959.07	
Surplus Reserved for New Building	25.00	
Surplus Reserved for Section on Medical History	636.65	
Total Net Worth		$109,197.57

RECONCILIATION OF NET WORTH
December 31, 1954

Net Worth—December 31, 1953		$168,311.78
Additions:		
Excess of 1954 General Fund Income over Expenses, Including $636.65 relating to Section on Medical History	$ 9,868.25	
Increase in 1954 of Net Worth of The Wisconsin Medical Journal	5,560.94	
Total Additions		15,429.19
		$183,740.97
Deductions:		
Adjustment to Furniture and Equipment Inventory at 12-31-54	$ 263.61	
Transfer of Capital to SMS Realty Corporation	74,279.79	
Total Deductions		74,543.40
Net Worth—December 31, 1954		$109,197.57

CONDENSED STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1954

INCOME		
Administrative and General Income		
Membership Dues—Current Year	$170,890.00	
Membership Dues—Prior Years	1,680.00	
Other General Income	2,975.50	
Total		$175,545.50
Other Income		
Public Health Information	$ 510.00	
Annual Meeting	21,196.75	
Clinics and Meetings	6,939.20	
Section on Medical History	890.00	
Interest Earned	217.79	
Building—Rent from Society Division	21,390.00	
Cafeteria	6,600.62	
Miscellaneous	4,763.43	
Total		62,507.79
Total Income		$238,053.29
EXPENSES		
Administrative and General Activities		
Executive Staff Salaries	$ 45,289.83	
Other Salaries and Wages	41,062.19	
Council, Officers, Delegates and Committees Expense	13,619.92	
All Other Administrative and General Expense	53,001.46	
Total	$152,973.40	
Other Expense		
Public Health Information	$ 14,440.99	
Annual Meeting	19,387.16	
Clinics and Meetings	9,188.92	
Interim Appropriations	5,296.50	
Amortization of Bond Premiums	6.75	
Building	18,026.47	
Cafeteria	8,864.85	
Total	75,211.64	
Total Expense		228,185.04
Excess of Income over Expense		$ 9,868.25

DETAILED STATEMENT OF INCOME AND EXPENSE

Year Ended December 31, 1954

INCOME			
Administrative and General Activities			
Membership Dues—Current	$170,890.00		
Membership Dues—Delinquent	1,680.00	$172,570.00	
Office Service		1,900.00	
A.M.A. Collection Service		701.97	
Miscellaneous Income		373.53	
Total			$175,545.50
Public Health Information			
Medical Service Panels			510.00
Annual Meeting			
Exhibit Rentals		$ 16,694.75	
Round Table Receipts		4,502.00	
Total			21,196.75
Clinics and Meetings			
Health Conferences		$ 396.20	
Industrial Health Clinics		455.50	
Postgraduate Teaching Clinics		6,087.50	
Total			6,939.20
Other Income			
Section on Medical History		$ 890.00	
Interest Earned		217.79	
Building—Rent from Society Divisions		21,390.00	
Cafeteria		6,600.62	
Miscellaneous Income		4,763.43	
Total			33,861.84
Total Income			$238,053.29
EXPENSES			
Administrative and General Activities			
President's Travel	$ 750.00		
Council, Officers, Delegates and Committee Meeting Expense	13,619.92		
Association Dues	776.25		
Resource and Informational Material	773.94		
Woman's Auxiliary	1,141.37		
Accounting	3,385.79		
Insurance	311.27		
Rent	7,680.00		
Telephone and Telegraph	1,791.72		
Office Supplies	3,262.22		
Postage and Printing	6,484.93		
Section on Medical History	258.35		
Upkeep and Fixtures	702.47		
Depreciation	2,105.59		
Legal Expense	5,073.75		
General Bulletins to Members	597.84		
Blue Book Issue	2,500.00		
Executive Staff Salaries	45,289.83		
Other Salaries and Wages	41,062.19		
Payroll Taxes	1,799.82		
Group Insurance Expense	1,051.35		
Retirement Program	4,682.40		
Staff Travel Expense	6,197.59		
Miscellaneous Expense	1,674.81		
Total		$152,973.40	
Public Health Information			
Telephone and Telegraph	$ 7.73		
Today's Health	489.00		
Special Bulletins	172.35		
Legislative Counsel	3,600.00		
Press Releases and Services	311.40		
Health Conferences, Exhibits and Publications	267.59		
March of Medicine Expense	2,737.08		
Applications and Correspondence	116.00		
Panel Printing and Postage	6,228.90		
Salaries and Wages—Other	100.00		
Payroll Taxes	2.00		
Miscellaneous Expense	408.94		
Total		14,440.99	
Totals carried forward		$167,414.39	$238,053.29
Totals brought forward		$167,414.39	$238,053.29
Annual Meeting			
Woman's Auxiliary	$ 500.00		
Insurance	10.00		
Auditorium Rental and Labor	1,703.50		
Expenses of Speakers	2,261.83		
Publicity and Program Expense	856.44		
Union Operation	169.40		
Scientific Exhibits	1,316.04		
Commercial Exhibits	2,205.24		
Stenotype Record	217.06		
Round Tables, Dinner, President's Reception and Guest Luncheon Expense	5,340.15		
Badges	26.50		
House of Delegates Expense	1,334.30		
Postage	350.00		
Machine Rentals	218.05		
Staff Expenses	1,694.84		
Miscellaneous Expense	1,183.81		
Total		19,387.16	
Clinics and Meetings			
Industrial Health Clinics	$ 356.31		
Postgraduate Teaching Clinics	7,004.94		
Councilor District Meetings	526.30		
Medical Clinics on Mental Deficiency	75.59		
Special Conferences	1,225.78		
Total		9,188.92	
Interim Appropriations			
Wisconsin Medical Journal	$ 4,200.00		
Wisconsin Veterans Medical Service Agency	533.56		
Other	562.94		
Total		5,296.50	
Other Expense			
Amortization of Bond Premiums		6.75	
Building—Old			
Insurance	$ 550.37		
Telephone and Telegraph	2,365.50		
Depreciation	3,518.18		
Salaries and Wages	6,319.13		
Heat, Light, Gas and Water	1,677.19		
Repairs	500.90		
Supplies	438.35		
Property Taxes	1,330.88		
Payroll	240.11		
Group Insurance Expense	90.58		
Mail Service	703.31		
Miscellaneous Expense	291.97		
Total		18,026.47	
Cafeteria			
Depreciation	$ 181.06		
Salaries and Wages	3,499.93		
Payroll Taxes	133.08		
Group Insurance Expense	84.06		
Food Purchases	3,789.93		
Beverage Purchases	1,065.21		
Miscellaneous	111.58		
Total		8,864.85	
Total Expenses			$228,185.04
Excess of Income over Expense			$ 9,868.25

REPORT OF THE SECRETARY

The following report of the secretary was published in the *Handbook for Delegates:*

The tradition of the report calls for it to be written in the third person with consistent reference to "your secretary."

At the moment I do not feel like writing a "traditional report." I will address you in the first person because I feel that there is a particular series of remarks that I want to make in light of that emphasis.

As your secretary and, therefore, your general manager, I have not been concerned over the inevitable fact that there will always be a State Medical

Society of Wisconsin. Times being what they are, in so far as I can gaze into the crystal ball, I am, however, concerned that it will always be a functioning and large organization. When that inevitable fact exists, it means that there must be depth to your employee organization. The loss of a key employee cannot be permitted to develop chaos or stagnation in an organization which is today responsible for the proper handling of funds totaling more than four and a half million dollars annually.

This concern on my part is not a new one, but it is one about which I have not been able to do much until recently.

Personnel charts are frequently characterized as "gas pipe plumbing"; and as I visualize the work of the State Medical Society, other than my own job with it, it seems at the present time to fall very naturally into three categories.

Scientific Medicine

The first and of basic importance are its activities in the field of scientific medicine. This series of responsibilities is the reason for the Society's existence; and without them, the Society would not be a professional association but merely a trade association.

Health Education

The second and larger, but no more important, are the activities in public health education, including its radio programs, its beginnings in the field of television, its responsibility in the legislative halls, its advice and contact with many other organizations, and the liaison which it develops through serving in an advisory capacity to many state departments and commissions.

Insurance Medicine

A third and recent responsibility is insurance medicine, which has been dramatic in its growth and rather tremendous in its implications to every practitioner in this and other states.

I see a fourth division, not now crystallized and perhaps never to be realized. That is the administration of medical and related care by governmental and semi-governmental agencies. The most obvious activity in this category would be in the public assistance field and the possibility of increased centralization of the administration of medical care for the aged, the indigent, pensioners, and other groups whose economic status is such that they require the assistance of all of society.

At any rate, out of this analysis I have endeavored to bring about a coordinating assistant in each of these several fields. Assistant Secretary Roy Ragatz, who is now with us but part time, heads a well-devised and highly realistic organization in the field of scientific medicine.

Earl Thayer has been promoted to the status of an assistant secretary to work primarily in the field of public health education and similar activities.

I report with pleasure to the House of Delegates that Mr. W. C. White, Jr., of Chicago, who is now serving as an associate in the organization of Carl A. Tiffany & Co., consulting actuaries, will join the Society's staff during midsummer in the position of an assistant secretary in the field of insurance medicine.

I believe that we are slowly but steadily achieving a desirable depth of organization. I hope that you feel that your Council and I, as your secretary, are fully aware of the organizational needs of the Society and are doing our best to achieve them.

Student Loan Fund

There is one other matter about which I feel you should have a report from me as secretary. Some several years ago, you authorized the establishment of a Student Loan Fund. While contributions to it have not been tremendously significant, they have been sufficient to permit loans to 14 medical students. Our experience, as a staff, in hearing of their needs, of being able to say that the Society had a fund especially designed for those needs, and knowing the tremendous satisfaction that comes about from helping a medical student over his financial hump, has been a great inspiration.

Out of that experience occurred a thought which came into reality and which, again, has given us a vast amount of pleasure and truly significant value. The program was instituted experimentally in 1954. It was to make a position available within the organization of Blue Shield to a second-year medical student who needed job employment during the summer and part-time work during the balance of the year.

The medical student was nominated by the dean of the University of Wisconsin Medical School. He started work last June in our Claims Department, actually working with the Physicians' Service Reports as they came in from all over the state. The background he had already acquired in his medical training gave him opportunity to work into the claims field very rapidly; and, obviously, it was a field of particular interest to him. Since our student went back to school last fall, he has worked part time in our office as a claims auditor, checking various batches of claims to see that they were paid in accordance with the schedule and under the various policy provisions.

I should like to say that every dollar paid to him by way of salary has been a fine investment. He has performed his work well and effectively. We will continue with a new medical student in this position in June of 1955, and perhaps this year—certainly by 1956—we hope to have two positions available to worthy medical students who are financing their own medical education, in whole or in part.

Our current employee is Edward W. Christensen of Racine, Wisconsin; and while we regret that he will not be able to serve us after this midsummer, we will look forward to that future day when he will be, we hope, among the members of the State Medical Society and a graduate of the Society's own offices as well as the medical school.

The New Building

Now I come to my final point. It is my feeling that 1955 marks a great event in the history of Wisconsin medicine. That is the realization that the State Medical Society will soon be housed in a building especially designed to meet its various needs, in a building of dignity, and in a building which assures for many years growing strength on the part of the medical fraternity. The building is not lavish, nor does it need to be. It is a building born of practical

considerations for the ever-expanding interests of the medical profession in serving public health needs.

Each of you is a part of this building. It is yours. It is a real example of the vitality of the medical profession in Wisconsin. The building is truly a consequential achievement, and I must confess that after these years of work with you, I cannot help but think of it as "our" building. I wish that I could express to you the pride that its construction has instilled in the staff. Again, because it is *your* building, it is my wholehearted and very sincere hope that you will make it a point to visit it whenever you can and to call upon those who are working there for their assistance at any time you should feel they may be of help to you.

1955 MEMBERSHIP REPORT AS OF MARCH 1, 1955

Members paying no dues		217
(affiliate members	54	
(military service members	92	
(honorary members	8	
(life members	63	
(total	217	
Members paying pro rata dues (military service)		4
Associate members ($10 dues)		48
Members in residency training ($3 dues)		138
Members paying $60 dues		2,867
Educational members ($45 dues)		2
Total membership		3,276

EXCERPTS FROM THE SPECIAL REPORT OF THE SECRETARY

As a supplement to the printed report, Mr. Crownhart presented the following special report:

Secretary Crownhart: It is the responsibility of the secretary on occasion to direct the attention of the House of Delegates to special problems which not only affect scientific medicine, but have economic and medico-legal implications as well.

This special report that I am now submitting has been prepared by me with the help of our legal counsel, Mr. Robert B. L. Murphy, for your consideration. It deals with the Principles of Medical Ethics and, in particular, Section 8 of Chapter I, which relates to the ownership of drugstores and dispensing by physicians, which acts would appear to be unethical except under circumstances requiring special consideration of the appropriate county medical society.

Out of the philosophy that there are conduct and motivation which are above either definition or enforcement by law, principles of ethics constitute a voluntary attempt to lead the conduct of those who are members of a profession into realms perhaps defined best as of the highest moral character.

Now, Section 8 of Chapter I does not state a principle of ethics. It states a factual circumstance qualified in such obscure and indefinite terms that no student of the subject can understand its meaning. This section appears to hold the fact that either the ownership of a pharmacy or dispensing by a physician is unethical conduct *per se*—unless adequate drugstore facilities are not otherwise available, a further fact which must be confirmed by the county medical society of the area.

What are true components of the adjective "adequate"? Webster defines it as meaning "Equal to or sufficient for some (specific) purpose," which in my mind is more a description than a definition. Applied specifically to the pharmacy, adequacy involves not alone physical distribution of pharmacists and pharmacies, but their necessary availability to the patient at all reasonable times and in emergency. Adequacy must be understood also to relate to those who have need of the service, and not only to those who prescribe that service. In other words, adequacy to the consumer is of paramount importance.

We have found that in Wisconsin, for example, there are slightly more than 1,100 drugstores, but 40 per cent of them are located either in the Milwaukee or the Madison metropolitan areas. Not all drugstores are staffed with more than one pharmacist; and some drugstores are confronted with a problem, at times, in absence of their pharmacist.

We find many physicians' offices are located quite conveniently to a reliable drugstore; yet, on the other hand, we find that the source of practice of those physicians may embrace a sufficient territory so that, as to some of their patients, the drugstore is reasonably available, but as to others it is substantially unavailable.

On the other hand, it is also a fact that patients are not always treated in the physician's office or in the hospital. Is the rural patient, sick at home, to be forced into the added expense and inconvenience of returning to the drugstore which is near the physician's office?

Beset not only with the offering of a prescription service, many pharmacies have other activities associated with their drugstore and cannot, under present circumstances, offer a day-and-night service. Only two years ago Dean Uhl of the School of Pharmacy of the University of Wisconsin remarked that there were then existing two or three well-paid positions for every pharmacist entering practice in Wisconsin.

The question of adequacy goes to the extent of stock that must be maintained by a drugstore to adequately meet the needs of the patients directed to its prescription service. In a recent legislative hearing, representatives of the Wisconsin Pharmaceutical Association stated that the complete modern drugstore must stock more than 15,000 items. Yet, there may be considerable doubt as to many pharmacists possessing such as extensive inventory.

That being true, it is quite understandable that, in those areas where no such inventory is maintained, the physician is actually forced into stocking items he believes necessary in his practice and which are not otherwise available. If by chance he stocks 10 items, and one of those is also carried in the drugstore, is the physician at that point 90 per cent ethical but 10 per cent unethical?

The anomalous character of this particular principle is self-apparent. If the locality possesses an adequacy of drug facilities, the physician cannot ethically engage in dispensing. If there is inadequacy, then the physician dispensing is ethical. But if the situation changes, and what was inadequate becomes adequate, then does the ethical dispensing physician become unethical without change in conduct?

It has been one of the most honored precepts of the medical profession that the ethical physician so conducts himself that he protects his patient from exploitation. What you in the medical profession

wish, I believe, is that the physician's professional income be derived *principally* from his professional services, and that any income related to his practice, but not derived solely from his services, should be *incidental* to his practice.

If I correctly conceive the professional motivation in this respect, then I stand firm in my judgment that Section 8, Chapter 1, is fundamentally erroneous in its present wording and may in fact lead to such a multiplicity of varying rules in county societies that the section will become ineffective.

As your secretary, I have great pride in your professional conduct and in the fine example which you set in Wisconsin. I should like to see Section 8 in such form and in such character that it stands as an ideal by which the medical profession may be properly guided in this professional conduct.

I recommend that the House of Delegates of the State Medical Society consider the following, to be offered to the American Medical Association for its consideration; namely, that Section 8 be abolished and that there be substituted in lieu thereof a statement about as follows:

> "The sale of appliances, devices, and remedies prescribed for patients is incidental to the practice of ethical physicians and is without exploitation of the patient."

Since Chapter VI, Section 3, of the By-Laws provides that "All questions of an ethical nature brought before the House of Delegates . . . shall be referred to the Council without discussion," and it is my belief that the subject of this report does raise questions of "an ethical nature," therefore it should be referred to the Council under that provision of the By-Laws.

On motion of Dr. A. J. Baumann, Milwaukee, seconded by Dr. R. L. MacCornack, Whitehall, carried, the special report of the secretary was referred to the Council without discussion from the floor.

Supplementary Necrology Report

Secretary Crownhart reported that since the listing of deceased physicians was published in the *Handbook for Delegates*, the following physicians had died:

D. H. Bruns, Phoenix, Arizona
J. D. Fuller, Lomira
W. J. Olsen, Sturgeon Bay
C. A. Pardee, Fort Myers, Florida
Bjarne Ravn, Merrill

The House of Delegates rose in silent tribute to these deceased physicians.

Excerpts from Address of the President of the Woman's Auxiliary

Mrs. Victor S. Falk, Edgerton: The scope of our activities is necessarily broad, inasmuch as the interests and talents of our 1,600 members, serving in the 34 organized auxiliaries covering 49 counties and as members-at-large in the unorganized areas, are so extensive.

A year ago Governor Kohler announced that right here in "America's Dairyland" half of the children failed to have the recommended three or four glasses of milk each day—in fact, one in ten didn't have any! Immediately, the State Auxiliary created a Child Health Committee to study the problems and seek solutions on behalf of Wisconsin's youngsters. We became interested in aspects other than nutritional deficiencies and decided we could render a great service by cooperating with Parent–Teacher associations. We subsequently studied school guidance and counseling techniques and integrated some phases of our child health and mental health plans.

Because at least 17,000 Wisconsin citizens today suffer from serious nervous disorders and mental health is a primary problem, the Auxiliary has worked with the Wisconsin Mental Health Association and contributed in various ways to the sanatoria in the state. We know that prevention is our challenge, and we realize that children have no recourse from unfavorable home and school situations. Therefore, we are promoting better mental health for our pupils—the theory being that education provides excellent intellectual training but does not in all instances adequately correlate emotional growth with the acquisition of superficial knowledge.

The Milwaukee and Eau Claire–Dunn–Pepin auxiliaries have pioneered programs we might all well study and follow. Mental health campaigns are today where tuberculosis drives were 40 years ago.

During 1954, as organization chairman, I helped five new auxiliaries establish themselves. The Jefferson County members extended their warm hospitality and entertained their husbands' office receptionists, medical technicians, and assistants this year. They also collected and mailed layettes to a Greek maternity hospital from which charity babies had previously been sent home wrapped in newspapers.

The longer-established Brown–Kewaunee–Door Auxiliary has since January 1, 1953, completely staffed the regional blood bank in Green Bay on nine full days, which represents approximately 2,200 working hours.

Although we have an Activities Book for County Presidents, which outlines our state and national program suggestions, we encourage independent, worth-while projects which are particularly adaptable in certain communities.

We want you to know that we contributed $1,207 to the American Medical Education Foundation this year.

We are extremely pleased about having an Auxiliary member serve as a vice-chairman for your Section on Medical History. At our midyear conference Dr. William D. Stovall and Mr. Donald McNeil, assistant director of the State Historical Society, explained "Why Wisconsin Needs a Medical Museum," sought our assistance, and gave us some specific assignments which we hope will accelerate its construction and progress.

Mrs. Robert Schmidt, our very enthusiastic state chairman of *Today's Health* magazine, realized great success this year and reported that 1,600 Wisconsin citizens "added life to their years and years to their lives" by subscribing to this magazine.

Mrs. N. A. Hill kept us legislatively posted, rep-

resented us at meetings of the Women's Legislative Council, and attended the Fourth Governor's Conference on Children and Youth, held in Madison.

Recently, I had the pleasure of hearing and watching Dr. Carl Neupert as he was interviewed and photographed by the press following a superb civilian defense lecture.

It is when I think of our nurse recruitment achievements that I don my most jubilant and approving expression. It is gratifying to review the results of our recent recruitment efforts. Last fall every school of nursing in this state enrolled a capacity freshman class, and the number of applications for admission reached an all-time high. This is a decided contrast to the desperate situation of past years, when schools were virtually closed because of the paucity of students, and entrance waiting lists were beyond the realm of anyone's imagination.

The Medical Auxiliary now sponsors 23 Future Nurse Clubs with a total membership of 900 girls throughout the state. Mrs. Albert G. Martin arranged and conducted the first state convention for prospective nurse students in Milwaukee on April 30; 175 high school delegates and representatives from 20 of the organized clubs attended the meeting. We hope funds will be available to make this convention an annual affair and to publish a newspaper printing news and publicity the clubs seem anxious to submit. Surveys show that doctors' wives contact and counsel more than 1,000 interested teenagers annually regarding the desirability of careers in nursing.

We are as proud as parents when our scholarship recipients graduate from approved nursing schools and are qualified to practice the profession. This year your wives offered $3,000 in gift nursing scholarships, $300 of which was available for practical nursing education.

Our loans in 1955 totaled $1,165. Since the inception of this project in 1952 we have given $700 to practical nurse students and $10,735 to girls enrolled in the three-year diploma course; $2,615 has been loaned, interest free, to deserving financially handicapped students. Presently, in Wisconsin, our acute deficiencies will be in the fields of trained practical and collegiate degree nursing. We will gear our scholarships accordingly.

No group is more anxious to improve patient care in Wisconsin than the Medical Auxiliary. Your purpose and ours are mutual. We are co-hosts to people humbled and frightened by disease, and together we hope to serve well all people who seek our help.

Before I close, I would like to remind you that the doctors in Clark, Iowa, Monroe, Price-Taylor, and Vernon counties have not sanctioned the organization of medical auxiliaries. We trust they will reevaluate and again appraise our program and deem it worthy of their support.

With unified strength and high purpose, may the State Medical Society of Wisconsin and the Woman's Auxiliary progress together, and rejoice in the thought that our combined efforts to help and preserve mankind will be fruitful and should, in some measure, revive the cherished and invincible spirit of human kindness.

Mrs. John J. Boersma of Green Bay, president-elect of the State Auxiliary, and Mrs. Mason G. Lawson of Little Rock, Arkansas, president of the National Auxiliary, were introduced by Vice-Speaker, J. W. Fons, Milwaukee.

Excerpts from Remarks of State Health Officer

Dr. Carl N. Neupert: It is a treasured privilege to appear before you each year, primarily because of the significance that goes with the invitation—that the physicians of the state and the State Board of Health, a governmental agency, are pulling together to improve the health of our people.

A mother's chances of not "doing well" are way down to a rate of 0.4 per 1,000 live births. But there are still too many deaths of infants soon after birth. There are still too many premature births. There are still too many unanswered problems having to do with the impact of the chronic diseases, those that incapacitate our people after middle age.

There is a bright side to this picture in that research is being stepped up phenomenally now as compared with only a few years ago, so that we can soon expect many answers not now at hand. Physicians are very well trained and ready to put the anticipated information into action. We are so much better off in the way of hospital facilities in which the newer knowledge can be applied all over the state.

However, in my judgment and in that of the State Board of Health which I represent, Wisconsin will be at a relative disadvantage in getting full benefit from these anticipated advances because of curtailment of your State Health Department through budget reductions. The budget bill, already passed in the Assembly and expected to pass in the Senate without modification, coupled with almost certain further reductions in federal funds this year and presumably greater reductions next year, spells reduction in staff and reduced activity by the State Health Department in the prevention of disease in Wisconsin.

There is another equivalent, possibly even greater, handicap to getting full benefit of these research activities that are almost surely just ahead; namely, our lack of qualified local health departments in other than a relatively few cities. Most states have a major part of their more rural counties served by full-time health departments. We have but one, in Eau Claire. We must still depend largely on one or two county nurses serving in some instances as many as 25,000 people.

The threat of atomic attack and all the havoc that goes with it are still very much with us. Our mobile medical teams have suffered a letdown during the past two years so that, although we are pretty well ready with supplies to do our job, there is much less assurance that teams will be ready to go into action.

Fortunately, we now have a full-time assistant co-director of health services in our office, Mr. Theodore Noe, who has already contacted many of you out in the field.

Finally, a word about the currently prominent matter of polio vaccine. The experts on whom we

have relied for our other licensed vaccines hold it to be safe, potent, and pure. The output of one manufacturer is being withheld from distribution at present. The vaccine of the other five is being released, all of it for the present to fulfill contracts with the National Foundation for first and second graders but, shortly, when that obligation is met, to regular distribution channels available to you all.

During the period of short supply, certain priorities are being advocated for voluntary compliance by physicians. This is to assure equitable, most effective use of the vaccine during this period that should be with us probably not over six months. The State Medical Society, through President McCarey, performed a real service to the children and parents in the state, and to you, in setting up an Emergency Consultation Committee on a few days' notice. You know of its recommendations which came to this House for action.

Both of these special activities are excellent examples of how physicians through their State Society can work cooperatively with the official agency in the interest of the people we serve. I trust nothing will ever hamper such a working relationship.

Remarks of Secretary of State Board of Medical Examiners

Dr. T. W. Tormey, Jr.: It has been felt for some time that a report to the medical profession of Wisconsin concerning the work of the State Board of Medical Examiners would be a desirable addition to the program of the Annual Meeting.

Briefly, this report will endeavor to acquaint you with (1) the composition, (2) the activities, and (3) some of the problems of the Board in this past year.

(1) The Examining Board is composed of eight members—seven M.D.'s and one D.O.—appointed by the Governor of Wisconsin. Under its direct supervision are also the three-member examining committee in chiropody and the three-member examining committee in physical therapy.

(2) The primary duties of the Board are the licensing of qualified individuals in the specific fields under its jurisdiction and the investigation and prosecution of violators of the Medical Practice Act, known as Chapter 147, of the Wisconsin Statutes.

In the past year we have examined 274 applicants for licenses to practice medicine and surgery—156 by written examination and 118 by oral or reciprocity examination. In addition, 41 physical therapy candidates have been examined. Also, nine chiropodists wrote the chiropody examination.

Under the revised law of 1953 permitting an annual quota of 25 unlicensed foreign graduates to take further training beyond their intern year, a total of 35 of these individuals have been interviewed at our last four meetings. These are known as holders of Temporary Educational Permits in Wisconsin. Thus, a total of 359 candidates have been examined and interviewed during the year 1954-1955.

Doctors in this last group, granted Temporary Permits, have come from countries named as follows: India, 4; Mexico, 5; Italy, 3; Philippine Islands, 7; France, 1; Germany, 4; Cuba, 1; Japan, 1; Austria, 2; Argentina, 1; Greece, 1; Chile, 1; Turkey, 1; Korea, 3. They requested permits for training in 16 of the 24 approved Wisconsin hospitals. A survey by this Board, as yet incomplete, indicates that this permit group is generally well accepted. Specific deficiencies in their training have been called to our attention.

Beginning in 1954, the Board of Examiners has taken over the publication of the annual registry at an increased expense to the Board of about $1,000 a year.

Since August, 1954, we have had a capable and alert investigator, a Wisconsin attorney-at-law, Mr. Donald C. Pressentin, carrying out the necessary work concerning violators of Chapter 147. He has been well received by, and has obtained the fine cooperation of, local authorities and those in the field of medicine in his work.

You are aware, of course, of his being instrumental in closing the so-called uranium tunnels, and in the conviction of an unlicensed individual practicing medicine, as well as the conviction of this man's associate for aiding and abetting him. The above are the more prominent of his accomplishments, but 93 other cases have been and are being investigated.

There is no question but that we are extremely fortunate in enjoying the excellent legal services of the attorney general's office in the persons of Mr. Stewart G. Honeck and Mr. Warren H. Resh. Mr. Owen Lewis of the Narcotics Division of the Federal Treasury Department is always a source of help to our Board, cooperating in problems in this field concerning the supervision of the use of narcotics.

We report with pride a splendid liaison with the deans of the two medical schools in Wisconsin and acknowledge their helpful advice in the educational field.

The Committee on Public Policy of the State Medical Society has listened patiently to our problems and has most graciously given of its time and help in introducing new and corrective legislation which we have recommended.

Being aware of the serious nature of the problem of licensing foreign graduates, not only in Wisconsin but elsewhere in the country, three of our Board members have this year attended the annual meeting of the Federation of State Medical Boards of the United States, held in conjunction with the Fifty-First Annual Congress on Medical Education and Licensure in Chicago. Our thinking is thus welded with that of boards on a national level. We have appointed our own committee to study the screening procedures, now proposed or in use, to evaluate graduates of foreign medical schools.

(3) Our problems are many, but the more pertinent include those dealing with the foreign and presently unqualified individual who wishes licensure in Wisconsin; how to place the presently allowed 25-a-year quota of Temporary Educational Permit applicants in 24 hospitals with 68 approved residency programs; and how best to maintain our treasury balance. As you know, we are what is known as a "self-sustaining Board," and receive no revenue from the state's tax funds.

I wish to thank you for the opportunity of presenting this report.

Additional Reports

Mimeographed reports of the Committees on Grievances, Public Policy, and Coordination of Medical Services were distributed to members of the House of Delegates, and others were published in the *Handbook for Delegates.*

Reference of Reports

Speaker Simenstad announced referral of reports to the following committees:

To the Reference Committee on Reports of Officers: Reports of the president, president-elect, treasurer, secretary, and A.M.A. Delegates; supplementary report of the Council; and report of the Committee on Coordination of Medical Services.

To the Reference Committee on Reports of Standing Committees: Reports of the Committees on Blood Banks, Civil Defense, Military Medical Services, Veterans Medical Service Agency, Cancer, Council on Medical Service, and Council on Scientific Work; report of the Council on "Guiding Principles of Occupational Medicine"; report of the Council on the Interprofessional Code; and report of the Committee on Public Policy.

To the Reference Committee on Resolutions and Amendments to the Constitution and By-Laws: Reports of the Council, Commission on Prepaid Plans, and Commission on State Departments; Dues for 1956; and reports of the Council re Physicians and the Social Security Act, of the Grievance Committee, and of the Emergency Consultation Committee on the Salk Vaccine.

Announcement was made of the time and place of the reference committee meetings so that any interested member of the Society might appear to present his views on any matter properly before them.

Committee on Nominations Selected

Following a councilor district caucus of delegates, on motion of Dr. G. W. Carlson, Appleton, severally seconded and carried, the following delegates were approved as members of the Nominating Committee.

District	*Nominee*
1	L. W. Schrank, Waupun
2	D. N. Goldstein, Kenosha
3	A. A. Quisling, Madison
4	E. C. Howell, Fennimore
5	E. C. Cary, Reedsville
6	H. J. Keif, Fond du Lac
7	R. L. MacCornack, Whitehall
8	C. E. Koepp, Marinette
9	E. P. Ludwig, Wausau
10	W. C. Henske, Chippewa Falls
11	C. J. Picard, Superior
12	S. W. Hollenbeck, Milwaukee
13	J. D. Leahy, Park Falls

Adjournment

The first session of the House of Delegates adjourned at 10 p.m., on motion of Dr. E. C. Cary, Reedsville, seconded by Dr. T. W. Tormey, Jr., Madison, carried.

SECOND SESSION

Wednesday, May 4, 1955

The second session of the House of Delegates convened at 7:40 p.m., Dr. L. O. Simenstad, Speaker of the House, presiding.

Report of Committee on Credentials

The Committee on Credentials verified the registration of 42 delegates and 15 alternate delegates entitled to vote at this session of the House of Delegates. In addition, four councilors and three officers registered their attendance.

On motion of Dr. J. W. Fons, Milwaukee, seconded by Dr. E. C. Cary, Reedsville, carried, the attendance roll of delegates and alternate delegates totaling 57 was accepted as the official roll of this session of the House, to stand for the entire session.

Introduction of Guests

Speaker Simenstad introduced the following guests of the House of Delegates:

Dr. D. W. Heusinkveld, president of the Ohio State Medical Society, Cincinnati.

Dr. L. A. Coffin, president-elect of the Iowa State Medical Society, Farmington, Iowa.

Dr. G. B. Saltonstall, councilor from the Michigan State Medical Society, Charlevoix, Michigan.

Reports of Reference Committees

REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS

This reference committee was composed of Drs. S. A. Morton, Milwaukee, chairman; W. D. Stovall, Jr., Brodhead; H. J. Kief, Fond du Lac; E. W. Humke, Chilton; and R. A. Thayer, Beloit. Doctor Morton presented the report.

REPORT OF THE PRESIDENT

The reference committee commended Dr. Arthur J. McCarey for his keen interest in the affairs of the Society and his devotion to the profession of medicine. Special note was made of two events which took place during his administration: one, the first Interprofessional Institute, which had been urged by the immediate past-president, Dr. H. Kent Tenney, Jr.; and, two, the first meeting in Wisconsin of the National Conference on Rural Health of the American Medical Association, which was held in Milwaukee in February and brought people to Wisconsin from all over the United States.

The reference committee agreed with Doctor McCarey that the Interprofessional Institutes should be continued on a periodically recurring basis; and on motion of Doctor Morton, seconded by Dr. E. W. Humke, Chilton, carried, this section of the report was accepted.

REPORT OF THE PRESIDENT-ELECT

In his address the president-elect, Dr. E. L. Bernhart of Milwaukee, not only reviewed major matters of concern to the profession and its activities in Wisconsin, but directed attention especially to the fact that Blue Cross deserved congratulations on its fifteenth anniversary. He pointed out the activities of Blue Shield and Blue Cross and urged their continued cooperation in accomplishing those results which will best serve the interests of the people of this state.

The reference committee concurred heartily with these recommendations; and on motion of Doctor Morton, seconded by Dr. T. W. Tormey, Jr., Madison, carried, this section of the report was accepted.

Doctor Bernhart also brought a serious message to the House concerning the problem of accident prevention and the importance of the medical profession's considering the great good that can be accomplished if the entire profession directs its attention to this problem. The reference committee was of the opinion that this subject would seem to be a matter within the jurisdiction of the Commission on State Departments in its cooperation with state health agencies, and therefore it recommended that the subject be referred to that Commission for further study.

On motion of Doctor Morton, seconded by Dr. J. F. Moon, Baraboo, carried, this section of the report was accepted.

REPORT OF THE TREASURER

The reference committee noted that the treasurer of the Society had made an encouraging report of the financial standing of the Society and expressed its appreciation of Dr. F. L. Weston's devotion to the financial and other affairs of the Society. On motion of Doctor Morton, seconded by Dr. J. H. Houghton, Wisconsin Dells, carried, the House accepted the recommendation of the committee that Doctor Weston be commended for his sustained efforts in the Society's fiscal affairs, as well as for his many other services which have come to be so deservedly appreciated by others.

REPORT OF THE SECRETARY

The committee stated that the activities of the Society staff, as reported by Mr. Crownhart, are under the immediate direction of the Council, officers, and committees and expressed its satisfaction that the delegates and the membership in general are receiving adequate reports with opportunity for full knowledge of the major matters of concern.

The committee further noted that the organization of the Society is involved and invited each member of the House to study for himself the organization chart of the Society which stood in front of the convention hall. It pointed out that, with some duplications on committees, substantially more than 300 physicians are actively engaged in the running of the affairs of the Society.

On motion of Doctor Morton, seconded by Dr. R. L. MacCornack, Whitehall, carried, this section of the report was accepted.

REPORT OF A.M.A. DELEGATES

The committee reviewed the published report of the A.M.A. delegates, which was circulated to the entire membership of the Society early last December following the interim meeting of the A.M.A. It was impressed with the breadth of the report as well as with the active participation of delegates and others at that meeting.

On motion of Doctor Morton, seconded by Dr. R. T. McCarty, Milwaukee, carried, this section of the report was accepted.

SUPPLEMENTARY REPORT OF THE COUNCIL

The committee noted that the supplementary report of the Council was primarily informational, including recent appointments made or confirmed by the Council. One item of the report called for attention and action of the House; namely, that Marquette University would celebrate its seventy-fifth anniversary during the coming academic year. The reference committee therefore proposed the following resolution:

Resolution on Marquette University

WHEREAS, The academic year 1955–56 will mark the seventy-fifth anniversary of the founding of Marquette University, and in that brief span of three-quarters of a century what began as an academy for young men has become a coeducational university which has won an honored place among the institutions of higher learning in this country; and

WHEREAS, That university today consists not only of a liberal arts college and graduate school but of eight other schools which offer professional and other advanced training; and those who have provided that institution with guidance have sought consistently and successfully to inculcate in their students the aim of their founder, St. Ignatius of Loyola, to help men develop morally and socially as well as intellectually, to the end that they may achieve wisdom as well as knowledge; and

WHEREAS, Marquette University has fostered rather than feared innovations in educational methods, and has endeavored to adapt itself to the needs of our industrial economy instead of seeking to force its students to conform to the tradition in education; and

WHEREAS, The Marquette University faculties have been ever mindful of the obligation of that institution, as a repository of the cultural heritage of the Western World, to pass on to each generation of its students some of the riches of Christian humanism; now, therefore, be it

RESOLVED, That the House of Delegates of the State Medical Society of Wisconsin, in Annual Meeting assembled, members of which represent the medical profession of this state and come from every corner of this commonwealth, extend its sincerest congratulations to the president, Father O'Donnell, the governing body, and the various faculties of Marquette University on the occasion of the Diamond Anniversary of its founding; and be it further

RESOLVED, That this House record its appreciation to those who have labored courageously and with dedication to build a monument to the human mind and spirit, and by so doing have earned the gratitude

of the State of Wisconsin and wide areas beyond its borders; and be it further

RESOLVED, That this House express its special gratitude to Marquette University for fostering and developing faculties and facilities for teaching and research in the physical, biological, and medical sciences, which have made possible the professional education of a substantial segment of the doctors of medicine of this and other states; and be it finally

RESOLVED, That a duly attested copy of this resolution be forwarded to the president and the dean of the Medical School of Marquette University, an institution of such merit that in honoring it we honor ourselves.

On motion of Doctor Morton, severally seconded, carried, this section of the report was accepted.

The following report of the Committee on Coordination of Medical Services was distributed to members of the House of Delegates in mimeographed form:

COMMITTEE ON COORDINATION OF MEDICAL SERVICES

J. F. Wilkinson, chairman; J. W. Nellen; R. B. Larsen; S. E. Gavin; and T. W. Tormey, Jr.

For many years the Committee on Coordination of Medical Services has had the privilege of reporting to the House concerning the general operations of Wisconsin General Hospital, with particular reference to the admission of patients and to policies governing referrals.

During the past several years the committee has been relatively inactive due to the fact that established policies have been adhered to carefully and there have been a minimum of complaints voiced by the profession concerning administrative procedures and violation of policies relative to referrals.

The committee has met with Dr. H. M. Coon, hospital administrator, to review the experience of Wisconsin General Hospital during the past year; and a report has been submitted comparing the years 1952–1953 and 1953–1954. It should be of interest to the physicians of the state that during 1953–1954 there has been an increase of only 57 private-pay patients over the year 1952–1953, with a total of 4,758 private patients in 1953–1954 out of a total of 13,038 admissions.

The committee has been gratified to note that the administration of Wisconsin General Hospital has attempted to correct a rather common complaint relative to delay of reports submitted to referring physicians. A special short form report has been devised to give the referring physician the basic findings and recommendations for therapy, and this has been provided physicians within a short time after patients have been discharged from the hospital.

The committee has given special consideration to problems which arise because referring physicians occasionally omit specifying whether the referral of special-rate patients is for diagnosis and treatment, for diagnosis and recommended treatment, or for diagnosis only. While the hospital has attempted to adhere to established policies, there has been an occasional instance of confusion which could have been rectified if the referral by telephone or by letter had specified the wishes of the referring physician.

In reviewing the general operation of Wisconsin General Hospital as a teaching institution, the committee noted the shift in surgical procedures, which emphasizes the fact that many surgical procedures heretofore performed at Wisconsin General Hospital are now being provided locally as specialized services become more prevalent throughout the state.

Special attention was directed to the current and future teaching program of the Orthopedic Hospital, and it should be of interest to the profession that the University of Wisconsin is developing special services for the cerebral palsied child as well as the child suffering from cardiovascular diseases. These services are being expanded as there has been a natural decline in the diversification of cases heretofore related to special problems of poliomyelitis.

The administrator of University Hospitals stated that the administration is well aware of the problem in connection with the special-rate patient who has hospital and medical care insurance, and that any assistance the State Medical Society can offer in settling it would be greatly appreciated.

In summary, the committee recommends that physicians confronted with special problems in relation to admission of patients to University Hospitals refer such problems to the State Medical Society so that the committee can function in accordance with its purposes. It is felt by the committee that the establishment of sound policies in reference to referrals has provided the teaching institution with the type and variety of patients needed for proper medical education and still has retained the basic right of the family physician to determine the course of therapy for his patients. It is gratifying to report to the House of Delegates that the absence of specific complaints referred to this committee reflects the successful operation of policies established by the House of Delegates in cooperation with authorities at the University of Wisconsin.

The reference committee urged each delegate to reread the report so that he might gain personal knowledge of its contents, which were believed significant both for the University Hospitals and for the medical profession.

On motion of Doctor Morton, seconded by Dr. D. M. Willson, Milwaukee, carried, this section of the report was accepted.

In conclusion, the reference committee expressed its appreciation for the excellent presentations by Dr. Carl Neupert, state health officer, and Dr. T. W. Tormey, Jr., secretary of the State Board of Medical Examiners, in behalf of their respective state bodies, and also for the gracious and informative report on activities of the Woman's Auxiliary by its president, Mrs. Falk.

On motion of Doctor Morton, seconded by Dr. T. W. Tormey, Jr., carried, the report as a whole was adopted.

REPORT OF REFERENCE COMMITTEE ON STANDING COMMITTEES

Dr. G. W. Carlson, Appleton, chairman, presented the report of this committee, which was composed of Drs. E. C. Cary, Reedsville; G. C. Hank, Madison; C. A. H. Fortier, Milwaukee; and R. S. Hirsch, Viroqua.

Doctor Carlson stated that the committee had not highlighted the main points of each report, assuming delegates had studied them.

COMMITTEE ON BLOOD BANKS

The reference committee felt that the recommendation of the Committee on Blood Banks should be approved and that no further comment should be necessary in urging county medical societies to give full support to the 1955 polio vaccine program.

On motion of Doctor Carlson, seconded by Dr. D. N. Goldstein, Kenosha, carried, this section of the report was accepted.

COMMITTEE ON CIVIL DEFENSE

The reference committee concurred with the recommendations of the Committee on Civil Defense, so ably headed by Dr. Marc Musser; and on motion of Doctor Carlson, seconded by Dr. L. E. Holmgren, Madison, carried, this section of the report was accepted.

COMMITTEE ON MILITARY MEDICAL SERVICE

The reference committee noted that, in connection with the report of the Committee on Military Medical Service, members of the House who were present Tuesday evening witnessed the very fine tribute paid to Dr. Frank Weston in recognition of his leadership, integrity, and diligent service as chairman of the Wisconsin Advisory Committee to Selective Service. The reference committee was fully appreciative of the part played by Colonel Bentley Courtenay and his assistant, Major Curt Shepard, in obtaining the national citation from Major General Lewis B. Hershey, national director of Selective Service, and recommended that the appreciation of the House of Delegates be expressed to Colonel Courtenay in a letter from the secretary's office.

On motion of Doctor Carlson, seconded by Dr. J. F. Moon, Baraboo, carried, this section of the report was accepted.

The following resolution was offered by the reference committee with the request that, if approved, it be transmitted to Doctor Weston:

WHEREAS, The House of Delegates of the State Medical Society is fully cognizant of the leadership, integrity, and diligent service which you have rendered as chairman of the Wisconsin Advisory Committee to Selective Service; and

WHEREAS, The appreciation of the House of Delegates has been expressed to Colonel Bentley Courtenay, state director of Selective Service, for his part in obtaining the national citation from Major General Lewis B. Hershey, national director of Selective Service; therefore be it

RESOLVED, That the House of Delegates record its hearty approval of the citation presented to you and its full support of the principles which you have so well exemplified in your chairmanship of the Wisconsin Advisory Committee.

On motion of Doctor Carlson, seconded by Dr. M. V. Overman, Neillsville, carried, this resolution and recommendations of the Committee on Military Medical Service were accepted.

THE VETERANS MEDICAL SERVICE AGENCY AND COMMITTEE ON CANCER

The reference committee reviewed the report of the Veterans Medical Service Agency, as included with reports of Council committees, and the following report of the Committee on Cancer:

COMMITTEE ON CANCER

R. P. Welbourne, chairman; A. R. Curreri; A. C. Taylor; P. B. Blanchard; K. G. Pinegar; R. B. Larsen; W. S. Bump; J. E. Conley; G. I. Uhrich; J. W. Conklin; Lucille Radke; R. J. Schacht; and Conrad W. Giesen.

Recommendations

1. Films and other valuable scientific material are available from the American Cancer Society and should be used by hospital staffs and county medical societies in their scientific programs.

2. Physicians are urged to attend the regional cancer conferences for physicians and dentists as a means of strengthening interprofessional responsibility for cancer detection.

3. County medical societies are urged to provide medical direction to organized county cancer committees in accordance with principles established by the Committee on Cancer of the State Medical Society.

During the past six months highly successful cancer conferences between dentists and physicians have been held in Sheboygan and Racine. The response suggests further development of similar programs. These meetings have also brought the two divisions of the Cancer Society in Wisconsin into close working relationship with the State Board of Health and the State Medical Society.

Cancer education continues to be emphasized in the circuit teaching programs and the Annual Meeting of the State Medical Society. Physician recognition should be given to the Wisconsin Division and the Milwaukee Division of the American Cancer Society for their encouragement and financial support of basic research at McArdle Institute at the University of Wisconsin and the Tumor Clinic at Marquette University.

There is greater need for physician participation in local cancer units. Since the program in Wisconsin has directed its primary emphasis to the patient-family relationship, the medical profession should willingly assist with further developments of lay activities based upon this fundamental principle of patient care.

Both of these reports were recommended for adoption; and on motion of Doctor Carlson, seconded by Dr. T. W. Tormey, Jr., Madison, carried, this section of the report was accepted.

COUNCIL ON MEDICAL SERVICE

D. E. Dorchester, chairman; R. L. MacCornack; D. M. Willison; J. S. Devitt; W. J. Fencil; T. D. Elbe; D. N. Goldstein; J. F. Maser; and H. J. Kief.

The following report appeared in the *Handbook for Delegates:*

Committee on Nursing

J. S. Devitt, chairman; G. S. Custer, Jr.; A. H. Heidner; G. B. Merline; R. C. Parkin; J. D. Schroeder; W. J. Tucker; J. H. Wishart; and Mrs. Victor S. Falk, Jr.

Standing Committee on Industrial Health

Elston Belknap, chairman; Thomas Burdon; D. E. Dorchester; David Goldstein; G. P. Gredler; J. V. Flannery; Gordon Petersen; Donald Ruch; J. M. Wilkie; and R. S. Wright.

The pressing problem of nursing education and service in Wisconsin has commanded a great deal of attention during the past six months.

During November, 1954, a commission created by the State Department of Nursing held conferences at Madison, Rice Lake, and Milwaukee as part of its survey to develop a state-wide plan for nursing education. Physicians were well represented at each of the three conferences. A wealth of local opinion and experience was made available to the survey team.

In January this committee met with the directors of the trained practical nursing schools in Milwaukee and Madison and the director of the State Board of Vocational and Adult Education. This developed into an exhaustive inquiry of existing facilities for trained practical nurses, problems in the operation of schools, and action needed to develop additional training programs in certain areas of the state. Whether state support will be available for the establishment of additional schools for trained practical nurses hinges in part on the results of a survey being conducted under the auspices of the State Department of Nurses. If the survey indicates more schools are needed, a joint meeting will be held between the Committee on Nursing and representatives of the State Board of Vocational and Adult Education, registered nurses, and hospitals to determine where such schools might best be located.

In February the Committee on Nursing made a number of recommendations to the survey team regarding matters which should be included in its final report. It was requested that among other things the report deal with:

1. An evaluation of present minimum qualifications of faculty members for nursing schools.

2. Needs for all types of nurses for all purposes in Wisconsin.

3. Training facilities required for present and estimated needs.

4. Feasibility of an itinerant faculty in training practical nurses.

5. The necessity of state subsidy for training programs for the R.N. or the T.P.N. in communities where the need for such programs exists but local funds for their support are lacking.

6. The advisability of a common basic training for diploma nurses and T.P.N.'s with the possibility of branching into either field at the completion of the basic training without loss of credit.

7. The possibility of rural affiliation for T.P.N.'s in training.

Also, in February, the Society agreed to participate with nursing and hospital groups in the establishment of a State-Wide Commission for the Improved Care of the Patient. This group will seek to develop means of improving nursing care of all types for patients in Wisconsin.

It is obvious that the results of these many activities regarding nursing will not be known for some time, but the implications are significant. The membership of the Society will be kept fully informed as progress is made.

Rural health received a stimulant with long-lasting effect at the Tenth National Conference on Rural Health held in Milwaukee, February 24–26, under the sponsorship of the American Medical Association. More than 500 participants exchanged a wealth of talk and ideas on farm and home safety, family responsibility for health, using available health and medical care resources, and how to do a good job in rural health. Described by the American Medical Association officials as "the best conference yet," the success of the meeting was due in large measure to the outstanding response of Wisconsin physicians in promoting and attending the session.

The Committee on Industrial Health is in the midst of revising the publication, "Industrial Health —A Guide for Medical and Nursing Personnel." "The March of Medicine" on radio continues to be one of the most popular radio features in Wisconsin. This 15-minute program is carried by 42 stations as a public service. The television version of "The March of Medicine" made its debut on WHA-TV. A series of 13 kinescoped programs is nearing completion. It is hoped this series will be available to county societies which wish to sponsor it on local stations throughout the state. An evaluation of television as a health education medium by the State Society will be presented for the next session of the House of Delegates.

The Physicians Placement Service has proved an extremely valuable adjunct of the Society's activity. At least 26 physicians have been placed in needed locations in Wisconsin since August, 1954. Currently, the Placement Service lists nearly 100 communities which seek physicians and about 85 general practitioners and 150 specialists who are seeking practices in Wisconsin.

The reference committee recommended special commendation to the Council on Medical Service for its assistance in the preparation for the Tenth National Conference on Rural Health held in Milwaukee in February. This conference, described by the A.M.A. officials as "the best conference yet," was successful largely due to the cooperation and assistance of the Council on Medical Service.

On motion of Doctor Carlson, severally seconded, carried, this section of the report was accepted.

Particular attention of the House was also called to the Physicians Placement Service of the Society which had been able to place almost 40 physicians in needed locations in Wisconsin during the last year. Communications from physicians and community representatives alike have indicated that the service is an extremely valuable project of the Society.

On motion of Doctor Carlson, seconded by Dr. E. W. Humke, Chilton, carried, this section of the report was accepted.

COUNCIL ON SCIENTIFIC WORK

P. A. Midelfart, chairman; S. A. Morton; M. G. Rice; L. G. Kindschi; K. E. Lemmer; R. S. Baldwin; J. S. Hirschboeck; and W. S. Middleton.

The following report of this Council appeared in the *Handbook for Delegates:*

It is gratifying to report that a continuing high level of professional education is being provided through the State Medical Society of Wisconsin. In the past six months the Society has developed a number of circuit teaching programs, two physician-dentist cancer clinics, a conference on mental deficiency, a series of programs related to maternal mortality, and the Annual Meeting. The support given to these programs by the members makes it possible to say with certainty that the medical profession in Wisconsin is alert to new developments in medical science and has had ample opportunity for re-emphasis of basic principles.

Ten circuit teaching programs have been held since the 1954 Annual Meeting. They were developed in cooperation with the State Board of Health, the Wisconsin Academy of General Practice, the two medical schools, and voluntary health agencies. About 400 members of the Society have taken advantage of these programs, and the enthusiasm expressed by those in attendance prompts the Council to recommend their continuation. Consideration is being given to holding more dinner-type meetings and making special efforts to build attendance.

The importance of special scientific programs on cancer for physicians and dentists has been clearly demonstrated. As further meetings of similar character are developed, it is hoped that physicians will give them full support by attendance and cordiality expressed to their colleagues in the dental profession.

The Mental Hygiene Division of the State Department of Public Welfare and the staff of Northern Colony, Chippewa Falls, provided a highly interesting and informative clinic for physicians last November. Those who attended expressed enthusiasm at the type of teaching material provided. This suggests the possibility of the development of a similar program at Southern Colony.

A number of changes have been made in the Annual Meeting program format. The basic function of an Annual Meeting program on the state level should be to provide new material for the general practitioner. Thus, the so-called "section meetings" have been dropped in favor of one large meeting with specialty subjects incorporated in the program. The traditional round-table luncheon discussions have been replaced by similar meetings without food service. It is hoped that the program prepared so efficiently under the direction of S. A. Morton, M. D., Milwaukee, will prove satisfying to those in attendance. The Council always seeks to improve the Annual Meeting in accordance with the wishes of the members. Comments on the 1955 program will be appreciated.

Constant change in medical postgraduate education prompts the Council to interest itself in the possibilities of television as a teaching device. The Council will meet during the next year with representatives of the two medical schools and other interested groups to explore the possibility of exerting leadership in television programs which might be provided to hospital staffs and other groups.

The Council would be remiss if it failed to include in this report a sincere note of appreciation to the many individuals within the Society who have assisted with the development of scientific programs since October, 1954. The University of Wisconsin Medical School and the Marquette University School of Medicine have been most generous in providing speakers for all types of meetings. In addition the staffs of state agencies have given teaching programs their fullest support.

In considering the report of the Council on Scientific Work the reference committee commended Dr. S. A. Morton, who had so well prepared the Annual Meeting program this year. In addition, all proposals of the Council were recommended for approval; and it was the opinion of the reference committee that the Council on Scientific Work itself should be permitted to determine whether the round-table discussions should be continued in the manner newly initiated this year, or whether the luncheon-type round tables should be resumed.

On motion of Doctor Carlson, seconded by Dr. H. J. Kief, Fond du Lac, carried, this section of the report was accepted.

REPORTS OF THE COUNCIL RELATING TO THE INTERPROFESSIONAL CODE AND THE GUIDING PRINCIPLES

The reference committee felt that the code for guidance of physicians and lawyers was an important step in the development of mutual understanding between these two groups and acknowledged the fact that Wisconsin is a leader in the development of such a code. The reference committee further proposed that the House accept the recommendation of the A.M.A. that the Guiding Principles of Occupational Medicine be approved as standards to be observed by physicians and others in providing medical service to industry.

On motion of Doctor Carlson, seconded by Dr. A. A. Quisling, Madison, carried, this section of the report was accepted.

COMMITTEE ON PUBLIC POLICY

J. M. Sullivan, chairman; J. R. Schroder; J. P. Conway; S. E. Gavin; J. K. Curtis; president, president-elect, and secretary, *ex officio.*

The following report was distributed to delegates in mimeographed form:

This is, in the true sense of the word, an "interim report." The State Medical Society's Committee on Public Policy has, as its chief responsibility, the implementation of the Society's legislative policies. This Annual Meeting finds your committee in the midst of the 1955 session of the Wisconsin Legislature. Like earlier ones, the current session brings to the State Medical Society many challenging public health problems.

In other years the committee has reported at a fall meeting of the Society. It either summarized the legislative activities in the health field during a session just completed or advised of the Society's legislative program for the session about to begin.

This interim report, then, is an experience new to the committee. Most of the action on bills of public health interest has yet to be taken by the legislature. This report is meant as a summary of certain of the proposals now before the legislature in areas of interest to the public health and, therefore, to the State Medical Society.

Mental Health

There are a number of legislative proposals which would alter the statutes controlling the commitment and treatment of the mentally ill. The most important of these results from a long-range study conducted by the Subcommittee on Commitment Laws of the Division on Mental and Nervous Diseases of the Commission on State Departments of the State Medical Society. The subcommittee was materially assisted in its study by representatives of the State Department of Public Welfare and the Wisconsin County Judges' Association.

The bill would adopt medical terminology in the classification of the mentally diseased. It would eliminate the epileptic from his present statutory association with the mentally diseased and would provide for better care of the person temporarily placed in custody prior to his commitment to a state mental institution. This measure, together with others dealing with the same subject matter, will be heard before the Senate Education and Public Welfare Committee during the week of the Annual Meeting, according to present understanding.

Medical Examiner System

Another legislative proposal, resulting from a long-range study of committees of the State Medical Society, would create the office of medical examiner in counties throughout the state. The medical examiner would perform the present duties of the county coroner in investigating the cause of reportable deaths.

Most of the work in preparing this legislative proposal was conducted by an *ad hoc* committee of pathologists headed by Dr. L. J. Van Hecke, medical examiner for Milwaukee County, which is the only county now authorized to appoint such an official. The proposal has been presented to the legislature under the co-sponsorship of the Wisconsin Bar Association, the Wisconsin Funeral Directors' Association, and the Wisconsin Chiefs of Police Association, as well as the Society. It has been heard by the Assembly Committee on State Affairs, which has reported it to the legislature with approval and for passage. Because the bill calls for an appropriation, it is now before the Joint Finance Committee for consideration.

Workmen's Compensation

In the workmen's compensation field there are several bills of interest to medicine. One of these, 405, S., would require a copy of the medical report to be presented to the compensation claimant. Another, 88, A., would require employers to designate "specialists" upon the posted workmen's compensation medical panels. Were this bill to pass, the State Medical Society would no longer be in a position to furnish the employers of this state with printed panels listing those members who wish to participate in the workmen's compensation program. It would obviously be impossible for the State Medical Society to compile a list of "specialists" acceptable both to the profession and to the public. The Committee on Public Policy has authorized opposition to these bills.

Wisconsin is one of the few states which has achieved a large measure of success in the development of a voluntary program for free choice of physician under workmen's compensation laws, and it is the belief of the Society that Bill 88, A. would destroy present accomplishments and would create an impossible situation for employer and employee alike. The only specialists now listed on the panel are those in the eye, ear, nose, and throat field; and the injured employee is able to determine the necessity of choosing their service. The bill does not contain any geographic limitation as to the specialists who are to be included on such a panel, and its definition of a specialist is loosely drawn.

Bill 88, A. is being opposed by the Medical Society for these and other reasons.

Unemployment Compensation

In the unemployment compensation field, there are several proposals of interest to the profession. One of these, 25 S., would extend the unemployment compensation tax to employers of one or more. The tax of 3 per cent will be imposed upon employers of four or more beginning in 1956, in conformity with federal legislation on the subject.

Narcotics and Dangerous Drugs

A rash of doubtless well-intentioned bills has been introduced relating to dangerous drugs and narcotics, but drafting problems and failure to reconcile regulatory measures with tax measures raise serious questions as to the advisability of consideration of these matters without more careful study.

At the request of the Wisconsin Pharmaceutical Association, a committee of the State Medical Society is currently conducting a study of both the narcotic and dangerous drug laws in an effort to resolve the confusion in this important field. This committee has taken the position that no unrealistic legislation can have its support; also that nothing must be done which imposes needless housekeeping and other regulations upon the profession.

Public Health Legislation

Under its general grant of authority the State Board of Health has conducted important activities in the tuberculosis control, industrial health, and dental health fields. With the anticipated further withdrawal of federal funds financing these activities, it is considered advisable to ask the legislature for recognition and approval of these activities. Accordingly, Bills 301, S., 558, A., and 302, S. have been introduced into the legislature. They would create separate divisions of tuberculosis control, industrial health, and dental health within the framework of the State Board of Health. All these bills have your committee's support.

Medical Practice Act

The Board of Medical Examiners has introduced Bill 511, A., which would make its representative on the State Medical Grievance Committee the secretary rather than the president. The permanent residence of the secretary in Madison makes this proposal advisable because the other two members of the Grievance Committee, the state health officer and a representative of the attorney general's office, are likewise residents of Madison.

In Bill 514, A., the Board of Medical Examiners recommends an increase in certain reciprocity and examination fees. It considers these increases necessary and justified in view of the Board's expanding activities.

Bill 512, A. would grant a temporary license to practice medicine in emergency situations calling for additional medical personnel in a particular area or institution. The Board or two of its officers would have to make findings that such a situation did exist. Such a license would be available only to persons fully qualified for licensure and would be valid only until the Board of Medical Examiners had the first opportunity to submit the applicant to examination. Such a temporary license would ordinarily be in force for less than six months and could not be renewed.

The State Medical Society has supported the two bills of the State Board of Medical Examiners and, with its cooperation, has developed Bill 512, A., which, by its own terms, would remain in effect for four years if passed. This means that at approximately that time the whole subject would be restudied and the field resurveyed as to the advisability of temporary licensing legislation.

Nursing Legislation

The State Board of Nursing had Bill 196, S. introduced. As originally drafted, it would have done away with the present statutory waiver of formal school requirements for a trained practical nurse, beginning in 1956. It also restated the grounds for revocation or suspension of a certificate of registration for a registered nurse. It substantially increased the penalties for violation of Chapter 149 of the statutes, relating to nursing. Also, there was sentiment favorable to an increase in the period of training for trained practical nurses to as much as 15 months. The present statutes fix a minimum of 9 months and a maximum of 12 months for such schools.

Bill 411, S. was introduced at the request of the Wisconsin State Nurses Association. This was an ambitious piece of legislation in its original form. It was believed objectionable from the public health viewpoint in at least two respects. The first was that it made mandatory the licensure of all types of nurses; namely, the graduate nurse, the registered graduate nurse, the trained practical nurse, and the practical nurse. Up to now, there have been no licensure or other requirements in so far as practical nurses are concerned. Second, the proposed definition of what constitutes "professional nursing" by registered nurses was objected to on the ground that by its wording it authorized nurses to engage in "treatment," also to execute "independent health procedures and techniques not requiring the supervision or direction of a physician." Further, it authorized nurses to conduct "health education and health conservation activities."

There have been extensive negotiations on these bills since early March through a conference committee which included representatives of the State Board of Nursing, the Wisconsin State Nurses Association, the two hospital associations, and the State Medical Society. It is believed that the objectionable features have now been eliminated, and it is expected that substitute bills will be introduced very shortly.

Cult Legislation

What appears to be the naturopaths' 1955 bid for recognition takes the form of an amendment to a chiropractic bill. All chiropractic proposals are before the Assembly Committee on Public Welfare and have been given public hearings. One chiropractic bill typifies the misleading character of chiropractic legislation. It appeared to require training characterized as preprofessional; but at the public hearing, it was admitted by the chiropractors that such training could be coextensive with the chiropractic courses, raising serious doubts as to the validity of the latter, and the seriousness of the former.

The Medical Society strongly opposed the measure and insisted that if chiropractors are to be required to have any collegiate training, it be in an institution which is recognized for that purpose and accredited by appropriate agencies. An amendment to that effect has been introduced, but it has not as yet been acted upon.

Another chiropractic effort has been directed in such fashion as to try to restrict investigation of the chiropractors' activities under state licensing laws. The chiropractors propose to increase their annual registration fee from $8 to $15, which would produce annual income to them of approximately $11,000. With this money they propose to hire an investigator who allegedly would enforce the Medical Practice Act in so far as it relates to chiropractors.

The State Medical Society has taken the position that the chiropractors can spend money in the way they see fit; but if they desire an investigator, he must limit his activities only to those sections of the statutes pertaining to chiropractic. The State Medical Society insists, however, that the State Board of Medical Examiners is the proper investigation agency for the entire Medical Practice Act, including those sections pertaining to chiropractic, and has offered an amendment to accomplish that result.

Bill 555, A., would exempt from the licensure requirements of the Medical Practice Act persons other than Christian Scientists who wished to treat the sick by spiritual means. Such an exemption was in the old Medical Practice Act but was taken out at the time of its revision two years ago. This bill is before the Assembly Committee on Public Welfare, which has not as yet scheduled it for hearing. Your committee has recommended opposition.

Bill 457, A., which was heard before an Assembly committee the legislative week of April 25, would forbid the Board of Health or any agent or employee from advocating the use of fluorides in drinking water. Your committee has authorized opposition to this bill because of its anti-scientific character and because of the knowledge that many cult and other fragment groups have united in what is really their opposition to medical science and to public health standards.

Recommendations

Your committee is following some scores of other bills on subjects which directly or indirectly relate to public health. Space and time forbid even their summary here. With reference to bills which have been reported here, your committee has followed the traditional position of the medical profession as to many measures and has carried out specific instructions as to the balance.

However, as noted earlier in the report, this is the first time, in recent years at least, in which the House of Delegates of the State Medical Society has been in session concurrently with sessions of the legislature. Simply to accept and approve this report would be inadequate in the estimation of the committee. For that reason we offer the following recommendations:

(1) Each delegate be instructed by this House to arrange an early meeting with the county society at which he may give a detailed summary with reference to this report.

(2) Legislative counsel and other staff members be available to the extent possible to attend such meetings in order to amplify and discuss these matters.

(3) The secretary be instructed to immediately message this report to officers of each county medical society, requesting their immediate cooperation in arranging the meetings outlined.

The reference committee recommended adoption of the committee's recommendations and urged that each county medical society set aside a special time for a discussion of these matters.

On motion of Doctor Carlson, seconded by Dr. J. H. Houghton, Wisconsin Dells, carried, this section of the report was accepted.

In conclusion, the reference committee recommended that the House commend all committee members for their unselfish and conscientious efforts on behalf of the Society involving many hours outside their practice. The committee recognized the assistance rendered by the office staff in Madison.

On motion of Doctor Carlson, seconded by Dr. C. E. Koepp, Marinette, carried, this section of the report was accepted.

On motion of Doctor Carlson, seconded by Dr. R. C. Strand, Eau Claire, carried, the report as a whole was adopted.

REPORT OF THE REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS

Dr. T. W. Tormey, Jr., Madison, chairman, presented the report of his committee, which was composed of Drs. Donald Willson, Milwaukee; H. A. Aageson, Oconto; W. C. Henske, Chippewa Falls; and E. D. Sorenson, Elkhorn.

REPORT OF THE COUNCIL

The reference committee commended the Council for its interest and guidance in the activities of the Commission on Prepaid Plans, and the first Wisconsin Interprofessional Institute, held in January of this year, which was most successfully attended, and for its vision in appointing the president-elect as an alternate delegate to the American Medical Association.

It further commended the Council for its long-range planning in the formation of the Charitable, Educational, and Scientific Foundation of the State Medical Society. It recommended adoption of the Articles of Incorporation and By-Laws but referred back to the Council the matter of voluntary billing and establishment of the amount of contributions.

The committee also reviewed the matter of section delegates and recommendations of the Council concerning them. In the interest of retaining the proper legislative organization of the House, the committee recommended adoption of the amendment to Section 1, Chapter XIII, directing the referral of requests for new scientific sections to the Council for its advice; but it did not recommend the adoption of the proposed amendment to Section 6.

The committee suggested that the Council might find it advisable to review the specialty sections now in existence in order to recommend the possible dele-

tion of such as are not functioning or active. The committee understood that, although it is a requirement that sections file organizational plans and by-laws with the Council, this has not been done; and thus the Council might wish to request such information.

On motion of Doctor Tormey, seconded by Dr. D. M. Willson, Milwaukee, carried, this section of the report was accepted.

RESOLUTION REGARDING SOCIAL SECURITY

The committee believed, as did the American Medical Association, that although it opposed the compulsory inclusion of physicians under the Social Security Act, it would not recommend opposition to legislation permitting physicians to voluntarily come in under the provisions of that law. Therefore, it recommended adoption of the resolution proposed by the Council on this matter.

On motion of Doctor Tormey, seconded by Dr. P. H. Gutzler, River Falls, carried, this section of the report was accepted.

EMERGENCY CONSULTATION COMMITTEE ON SALK VACCINE

The committee strongly endorsed the statements of President McCarey concerning the Emergency Consultation Committee with respect to distribution of the Salk vaccine and concurred with his opinion that the public-spirited leadership shown by the committee members should be highly commended. To more strongly urge the proper use of the vaccine, the committee recommended that any deviation by physicians from the suggested outline or recommendations be considered as questionable ethical practice.

It was moved by Doctor Tormey and seconded by Dr. E. W. Humke, Chilton, that this section of the report be accepted. Dr. J. P. Conway of Milwaukee here proposed that the vaccine be more correctly referred to as the vaccine against poliomyelitis by Doctor Salk. This change was accepted by Doctors Tormey and Humke; and the motion, when put to a vote, was carried unanimously.

COMMISSION ON PREPAID PLANS

The reference committee recognized the untiring efforts and guidance of the Commission's chairman, Dr. E. M. Dessloch of Prairie du Chien, and the foresight of the Commission as a whole in constantly studying problems involving prepaid insurance, not only on state, but national, levels. It seemed apparent from the increased number of individuals covered under Wisconsin Physicians Service and the Wisconsin Plan, and the claims handled, that the program is a successful and growing one. The reference committee recommended emphatic approval of the activity and direction of this Commission.

On motion of Doctor Tormey, seconded by Dr. T. E. Farrell, Prairie du Chien, carried, this section of the report was accepted.

COMMISSION ON STATE DEPARTMENTS

This Commission had indicated continuing activity on the part of approximately 100 Wisconsin physicians, in cooperation with representatives of various state agencies concerned with public health and welfare. The numerous active and anticipated projects have a direct bearing on the improvement of health in various segments of the state's population.

To highlight some of the activities of the Commission, the reference committee pointed out the very successful school health conferences held in two areas of the state, in which over 1,000 participated; the prematurity institute; the fetal-neonatal survey; the work of the Maternal Mortality Study Committee; and the extensive revision of the commitment laws proposed in Wisconsin in this legislative session.

The suggested projects and activities of this important committee of the Society were recommended for endorsement without hesitancy by the House.

On motion of Doctor Tormey, seconded by Dr. F. E. Drew, Milwaukee, carried, this section of the report was accepted.

COMMITTEE ON GRIEVANCES

R. E. Fitzgerald, chairman; E. W. Mason; E. D. Sorenson; F. A. Nause; H. W. Wirka; C. D. Neidhold; C. B. Hatleberg; and J. L. Moffett.

The following report of the Committee on Grievances was distributed to the House in mimeographed form:

In 1953 this committee reported to the House that if its activity is to be retained and its responsibilities properly discharged, the House must consider the necessity of adequate financing. It reported that an analysis of its cost and a general review of its work would be submitted to an ensuing session for detailed consideration.

The work undertaken through the mechanisms of this particular committee falls in fields well recognized by the profession. They are prevention, treatment, and alleviation.

In illustration of the first a reprint of the committee findings submitted to the House in 1953 was circulated to all county medical societies and is provided new members of the Society.

A most important task now has been completed, following three years of negotiation and conference with representatives of the Wisconsin Bar Association. The Interprofessional Code, reported to the House last fall, will be circulated to all members of the State Medical Society and the Wisconsin Bar Association during this coming midsummer. Plans are being made to provide copies annually to the senior class members of the four schools of medicine and of law in this state, as well as to those physicians who become members of the Society and those attorneys affiliating with the Wisconsin Bar

Association. Your committee is fully aware that in the years ahead various revisions and refinements may be necessary but feels that the code will, in time, eliminate areas of doubt and conflict which now cause inconvenience and loss of time and patience for members of each of the professions.

With this project completed, the committee, in cooperation with the Wisconsin Bar Association, will turn next to the matter of hospital and physician records and their status under laws relating to confidential communications. This conjoint study will, it is hoped, lead to the development of another and somewhat similar statment of mutual understanding and may very possibly indicate some revision of current statutory provisions in the field.

Your committee's activity falling in the field of "treatment" is concerned primarily with the handling of inquiries of patients and others who, for various reasons, are either dissatisfied or concerned with the adequacy of medical care, its availability, or its cost. There is no effective way of summarizing these matters, for no inquiry seems to fall into some natural category. Few, a very few, relate to the billings of physicians and, on carefully developed inquiry and gathering of all available facts, are often illustrated to be patient ignorance of the problem compounded by the physician's failure properly to explain the problem, and in language understood by the laity. An occasional situation arises where some distraught relative, not primarily responsible for the care of the patient, has misgivings as to the adequacy of care financed by others and associates the physician with his misgivings. Some cases are simply personality conflicts, most difficult to satisfy where the physician is the only one available in a particular community. There are situations, also, where the physical burden upon a particular physician has become overwhelming and leads to poor patient and public relationships. The vast amount of "public health education" (so called)—poorly written syndicated columns, feature stories of one sort or another, radio and TV programs of current popularity today—cannot help but create psychological problems for many who are sick and despondent. The committee feels that it often has been of practical assistance in this area of inquiry, able to reassure individuals and to restore that confidence which is so fundamental in the care of the sick. There are situations, of course, which raise legitimate inquiries as to ethical standards and practices, some presented by physicians themselves and others presented by their patients. Sometimes we of the profession, and often much of the laity, do not fully understand that a code or a statement of ethics actually endeavors to state an ideal, the ultimate to be achieved but not always possible as a practical matter, or because in the final analysis the physician is just another human being and to err is human. The Principles of Medical Ethics importune the highest of ethical conduct and consideration, and their constant restatement to the profession in Wisconsin through the mechanisms of *The Wisconsin Medical Journal* and otherwise is a project of which we may well be proud.

In the field of "alleviation" we come to those matters where the committee, always in consultation with other groups within the Society, is of the belief that a physician's general conduct over a period of time requires careful consideration. The committee has recommended in two situations since 1953 that a physician refrain from private practice until such time as rehabilitation is complete, and rehabilitation has been undertaken under general supervision of the committee itself. In several situations the committee has felt the matter to be beyond possibility of control by it as a body of the Society which can act only informally. Such matters have been referred to administrative tribunals of official standing.

It must be apparent that the projects under direction of the committee are at substantial cost, and a cost which has not been separately considered by the House of Delegates in its determination of annual dues. Investigation of individual matters is painstakingly extensive. It must be. Individuals filing inquiries with the Society are generally interviewed one or more times by the staff and at the direction of the committee. A complete work-up of every inquiry which appears to be legitimate is undertaken so that the committee may have an accurate understanding of the problem involved. None of the material can be verified under mechanisms similar to court procedure, but the committee feels it important that practical ways to accomplish a somewhat similar result are imperative. Facts are checked and double checked. Many times records are photocopied, and in each inquiry of major substance one committee member is fully "briefed" as the case progresses so that he may advise the committee as a whole of his reactions as well as instruct the staff in the preparation necessary. In one case the complaint involved the adequacy of medical testimony. At Society expense an 86-page transcript of the testimony was obtained and reproduced for each member of the committee. All of these efforts are expensive, and they have been an extremely heavy work burden on the staff. Your committee reported in October, 1954, that in the eight-month period ending June 30 of that year the total *direct* expense was in excess of $3,300 and that, in its opinion, the additional *indirect* expense (filing space, supplies, unallocated staff time, etc.) would bring the annual total to about $10,000.

Completion of the year 1954 showed the total direct expense to have been more than $4,500. But the dollar outlay is not as important as is time. Our present staff is not sufficiently implemented to handle these matters as promptly or as fully as is desirable. The committee registers no complaint as it is understanding of the work which has been added to staff responsibility since 1951, when dues were raised from $50 to $60 effective in 1952. There has been no adjustment since that time for the four-year period including 1955.

Your committee firmly believes that its activities and responsibilities, fully discharged, would be at a cost in excess of $12,500 annually. In 1954 your committee recommended that the question of implementation of this work be discussed with local county societies for their general consideration of the financial problem and that the House specifically consider the matter in 1955.

The reference committee felt that the report of the Committee on Grievances presented many interesting facets. One was its review and approval of the Interprofessional Code, which had been con-

sidered by the Reference Committee on Standing Committees. The Committee on Grievances will undertake next a review of hospital and physician records in order to develop another and somewhat similar statement of mutual understanding.

But the prime activity of the Grievance Committee had been the handling of problems, whether from patients, relatives, or others, concerned with the adequacy of medical care. In this last category these problems involved extensive interviewing, the collection of facts and data, and the consideration of this information in each case before decisions or recommendations could be made. These activities cost money.

In addition to requiring considerable time on the part of members of the committee and the Society's staff, the job is one that could not be done "half way" to obtain proper results; and the reference committee felt that financial implementation of the program was indicated.

The reference committee felt that the Committee on Grievances deserved the appreciation of the House and the membership as a whole for its efforts and work in connection with these matters. It further recommended that the House consider very seriously the financial problem which would receive recommendations in the next section of this report.

On motion of Doctor Tormey, seconded by Dr. M. J. Werra, Waukesha, carried, this section of the report was accepted.

DUES FOR 1956

The reference committee noted that there had been no increase in dues since 1952, and that not only were there increased work and projects which must be handled by the Society's staff, but the cost of providing that work and properly maintaining the activities of the Society had increased. The reference committee reviewed the well-prepared financial report, cost accounting figures of some of the activities, and the budget, as approved by the Council.

These financial considerations, together with the information reported by the Grievance Committee, indicated to the reference committee the advisability of recommending an increase of $5 in dues, to a total of $65, for the year 1956.

Doctor Tormey added his personal assurance that the recommended increase in dues in no manner related to the financing of the new building of the State Medical Society but related entirely to the matter of the Society's activities.

On motion of Doctor Tormey, seconded by Dr. G. W. Carlson, Appleton, carried, this section of the report was accepted.

On motion of Doctor Tormey, severally seconded, carried, the report as a whole was adopted.

Adjournment

On motion of Dr. J. F. Moon, Baraboo, seconded by Dr. J. H. Houghton, Wisconsin Dells, carried, the second session of the House of Delegates adjourned at 8:30 p.m.

THIRD SESSION

Thursday, May 5, 1955

The third session of the House of Delegates convened at 8:45 a.m., Dr. J. W. Fons, Vice-Speaker, presiding.

Report of Committee on Credentials

The Committee on Credentials verified the registration of 39 delegates and 14 alternate delegates entitled to vote at this session of the House of Delegates.

The Credentials Committee was informed by the secretary of the Winnebago County Medical Society of the appointment of Dr. J. P. Canavan to act as delegate for that society in place of the regular delegate and alternate, who were unable to attend. In addition, one councilor registered his attendance.

On motion of Doctor Fons, seconded by Dr. E. C. Cary, Reedsville, carried, the attendance roll of delegates, alternates, and the specially appointed delegate totaling 53 was accepted as the official roll of this session of the House, to stand for the entire session.

Report of Committee on Nominations

Dr. R. L. MacCornack, Whitehall, chairman of the Committee on Nominations, presented the names of the following nominees for official positions in the State Medical Society:

For President–Elect: Dr. L. O. Simenstad, Osceola;
For Speaker of the House: Dr. J. W. Fons, Milwaukee;
For Vice-Speaker of the House: Dr. H. J. Kief, Fond du Lac;
For Delegate to the A.M.A. to succeed Dr. W. D. Stovall: Dr. W. D. Stovall, Madison.
For Alternate Delegate to the A.M.A. to succeed Dr G. E. Forkin: Dr. C. E. Koepp, Marinette.

On motion of Doctor MacCornack, seconded by Dr. A. A. Cantwell, Shawano, carried, the report was received by the House of Delegates.

On motion of Dr. E. D. Sorenson, Elkhorn, seconded by Dr. G. W. Carlson, Appleton, carried, the various nominees were placed in nomination.

On motion of Dr. E. C. Cary, Reedsville, seconded by Dr. S. E. Zawodny, Milwaukee, carried, Doctor Simenstad was unanimously elected to the office of president-elect. Vice-Speaker Fons appointed Doctor MacCornack, Dr. E. C. Howell of Fennimore, and Dr. E. C. Cary of Reedsville as a special committee to escort the president-elect to the platform.

Doctor Fons then called upon President McCarey to assume the chair. On motion of Dr. J. F. Moon, Baraboo, seconded by Dr. G. W. Carlson, carried, Doctor Fons was unanimously elected Speaker of the House. Doctor Fons then resumed the chair.

On motion of Dr. George Schwei, Menasha, seconded by Dr. E. W. Humke, Chilton, Doctor Kief was unanimously elected Vice-Speaker of the House.

On motion of Dr. S. E. Zawodny, Milwaukee, seconded by Dr. D. N. Goldstein, Kenosha, carried,

Doctor Stovall was unanimously re-elected delegate to the A.M.A.

On motion of Dr. C. J. Picard, Superior, seconded by Dr. H. J. Kief, Fond du Lac, carried, Dr. C. E. Koepp, Marinette, was unanimously elected alternate delegate to the A.M.A.

Doctor Fons announced that Milwaukee had been selected by the Nominating Committee as the choice for the place for the next Annual Meeting of the Society. On motion of Dr. G. W. Carlson, Appleton, seconded by Dr. J. H. Houghton, Wisconsin Dells, carried, Milwaukee was selected for the next Annual Meeting.

Election of Councilors

The House then proceeded to the election of councilors, with the following results:

In the Third District, on nomination of Dr. A. A. Quisling, Madison, severally seconded, carried, Dr. N. A. Hill, Madison, was unanimously re-elected.

In the Fourth District, on nomination of Dr. T. F. Farrell, Prairie du Chien, seconded by Dr. D. J. Taft, Richland Center, carried, Dr. E. M. Dessloch, Prairie du Chien, was unanimously re-elected.

In the Fifth District, on nomination of Dr. P. B. Mason, Sheboygan, severally seconded, carried, Dr. A. H. Heidner, West Bend, was unanimously re-elected.

In the Sixth District, on nomination of Dr. H. J. Kief, Fond du Lac, severally seconded, carried, Dr. G. W. Carlson, Appleton, was unanimously elected to succeed Dr. Arthur J. McCarey of Green Bay, who did not wish to run for office.

In the Twelfth District, on nomination of Dr. S. W. Hollenbeck, Milwaukee, seconded by Dr. F. E. Drew, Milwaukee, carried, Dr. James P. Conway of Milwaukee was elected to succeed Dr. W. T. Casper, Milwaukee.

Acceptance of the President-Elect

Dr. L. O. Simenstad was escorted to the platform by the special committee which had been appointed by the Vice-Speaker. In his speech of acceptance, Doctor Simenstad made the following remarks:

"Not many of you can be president-elect of a great medical society, but I can assure you it is a thrill. I enter this position rather humbly, because I have been a member of this Society for 30 years and I realize fully that the officers are not always the highest and best men in the Society. The only reason I am here is because I have a lot of friends who pushed me into this job, and all of a sudden here I am.

"I do appreciate it, and I also appreciate all the fine friends I have. I hope that all of us will work together to continue to make this a very fine, great Medical Society. By this I do not mean that we should all have the same opinions. I think we should all have our own opinions, we should discuss them without rancor, and out of our discussions will then come a great and strong organization.

"Again, I thank you; and I am sure that we will all get along very well together. I hope you all will feel free to discuss whatever problems you have with me or any of the other very fine people associated with me. Your secretary, Mr. Crownhart, as you know, is a very excellent administrator.

"Thank you very much."

Doctor Swenson Introduced

Vice-Speaker Fons introduced Dr. Arnold Swenson, president of the Minnesota State Medical Association, who extended greetings from his Association and its secretary, Mr. R. R. Rosell, who could not be present.

Vote of Thanks to Officers

On motion of Dr. E. C. Cary, Reedsville, severally seconded, carried, a rising vote of thanks was given to the retiring officers for their services during the past year.

Adjournment *Sine Die*

On motion of Dr. R. L. MacCornack, Whitehall, seconded by Dr. F. E. Drew, Milwaukee, carried, the House of Delegates adjourned, *sine die*, at 9:15 a.m.

MINNESOTA ACADEMY OF GENERAL PRACTICE REFRESHER COURSE

The Minnesota Academy of General Practice will hold its fifth annual fall refresher course at the Radisson Hotel, Minneapolis, on Wednesday, October 19, starting at 8:30 a.m.

Seven hours of accredited postgraduate study will be provided in the form of concentrated instruction and lectures by 14 eminent medical authorities. The highlight of the noon luncheon will be a talk by H. E. Rynearson, M. D., Rochester, Minnesota. Some of the others on the full-day program will be Bert Seligman, M. D., Toledo; Gene Stollerman, M. D., University of Chicago; and George Logan, M. D., Rochester, Minnesota.

No charge will be made for registration. Purchase of a $5 luncheon ticket is the prerequisite to attendance.

A warm welcome to participate is extended to all doctors of medicine. Advance registrations are considered most advisable and should be made through:

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1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* 19:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* 14:323, May 1950.

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Attendance at House of Delegates
May 3, 4, and 5, 1955

Society	*Physicians**	*Sessions* 1	2	3
Ashland–Bayfield–Iron	J. W. Prentice, Ashland	o	o	o
	J. M. Jauquet, Ashland	o	o	o
Barron–Washburn–Sawyer–Burnett	J. R. Guy, Barron	x	x	x
	R. C. Thompson, Cumberland	o	o	o
Brown–Kewaunee–Door	L. C. Miller, Green Bay	x	x	x
	P. F. Dockry, Green Bay (deceased)	o	o	o
	R. M. Waldkirch, De Pere	o	x	x
	S. L. Griggs, Green Bay	o	o	o
Calumet	E. W. Humke, Chilton	x	x	x
	A. C. Engel, New Holstein	o	o	o
Chippewa	W. C. Henske, Chippewa Falls	x	x	x
	J. J. Sazama, Chippewa Falls	o	o	o
Clark	M. V. Overman, Neillsville	x	o	x
	J. W. Johnson, Withee	o	o	o
Columbia–Marquette–Adams	J. H. Houghton, Wisconsin Dells	x	x	x
	R. F. Inman, Montello	x	o	x
Crawford	O. E. Satter, Prairie du Chien	o	o	o
	T. F. Farrell, Prairie du Chien	x	x	x
Dane	L. E. Holmgren, Madison	x	x	o
	J. R. Steeper, Madison	o	o	o
	M. T. Morrison, Mount Horeb	x	x	x
	J. A. Grab, Sun Prairie	x	x	o
	T. W. Tormey, Jr., Madison	x	x	x
	R. M. Becker, Madison	o	x	o
	C. W. Stoops, Jr., Madison	x	x	x
	R. P. Sinaiko, Madison	o	x	x
	G. C. Hank, Madison	x	x	x
	R. J. Hennen, Madison	o	o	o
	A. A. Quisling, Madison	x	x	x
	John T. Sprague, Madison	o	o	o
Dodge	A. B. Kores, Beaver Dam	o	o	o
	L. W. Schrank, Waupun	x	x	x
Douglas	Charles W. Giesen, Superior	o	o	o
	C. J. Picard, Superior	x	x	x
Eau Claire–Dunn–Pepin	R. C. Strand, Eau Claire	x	x	o
	Robert Lotz, Eau Claire	o	o	o
Fond du Lac	H. J. Kief, Fond du Lac	x	x	x
	Howard Mauthe, Fond du Lac	o	x	x
Forest	E. F. Castaldo, Laona	o	o	o
	B. S. Rathert, Crandon	o	o	o
Grant	E. C. Howell, Fennimore	x	x	x
	M. W. Randall, Boscobel	x	o	x
Green	W. D. Stovall, Jr., Brodhead	x	o	o
	D. E. Mings, Monroe	o	x	x
Green Lake–Waushara	Russell Pelton, Markesan	o	o	o
	L. S. Shemanski, Wautoma	o	o	o
Iowa	C. L. White, Mineral Point	o	o	o
	S. B. Marshall, Hollandale	x	x	x
Jefferson	F. A. Gruesen, Fort Atkinson	x	o	o
	Raymond W. Quandt, Jefferson	o	x	o
Juneau	J. S. Hess, Mauston	x	x	x
	J. H. Vedner, Mauston	o	o	o
Kenosha	D. N. Goldstein, Kenosha	x	x	x
	Louis Olsman, Kenosha	o	o	o
La Crosse	R. L. Gilbert, La Crosse	o	o	o
	R. W. Ramlow, La Crosse	x	x	x
Lafayette	L. L. Olson, Darlington	o	o	x
	R. E. Oertley, Darlington	x	x	o
Langlade				
Lincoln	R. G. Baker, Tomahawk	x	x	x
	K. A. Morris, Merrill	o	x	x
Manitowoc	E. C. Cary, Reedsville	x	x	x
	R. G. Strong, Manitowoc	o	o	o
Marathon	E. P. Ludwig, Wausau	x	x	x
	D. M. Green, Wausau	o	o	o
Marinette–Florence	C. E. Koepp, Marinette	x	x	x
	J. W. Boren, Jr., Marinette	x	o	x
Milwaukee	I. J. Ricciardi, Milwaukee	o	x	o
	H. J. Lee, Milwaukee	x	o	o
	E. R. Daniels, Milwaukee	o	o	o
	E. P. Bickler, Milwaukee	o	x	o
	F. E. Drew, Milwaukee	x	x	x
	G. E. Collentine, Jr., Milwaukee	x	o	x
	J. W. Fons, Milwaukee	x	x	x
	J. E. Conley, Milwaukee	x	o	o
	J. P. Conway, Shorewood	x	x	x
	A. F. Tessier, Milwaukee	x	x	o
	J. V. Herzog, Milwaukee	o	o	o
	D. V. Elconin, Milwaukee	x	o	o
	S. W. Hollenbeck, Milwaukee	x	x	x
	M. S. Fox, Milwaukee	o	o	x
	W. J. Houghton, Milwaukee	x	x	x
	P. F. Hausmann, Milwaukee	o	o	o

*Indented names are those of alternates.

Society	Physicians*	Sessions 1	2	3
	G. S. Kilkenny, Milwaukee	o	o	o
	G. W. Hilliard, Milwaukee	x	x	x
	L. P. Stamm, Milwaukee	x	x	x
	R. L. Rice, Milwaukee	x	x	o
	C. A. H. Fortier, Milwaukee	x	x	o
	I. B. Reifenrath, Milwaukee	o	x	o
	A. J. Baumann, Milwaukee	x	x	x
	E. A. Habeck, Milwaukee	o	o	o
	J. B. Wilets, Milwaukee	x	x	o
	R. E. Callan, Milwaukee	o	o	o
	R. F. Purtell, Milwaukee	x	x	x
	D. W. Ovitt, Milwaukee	x	o	o
	S. L. Chojnacki, Milwaukee	x	x	o
	S. E. Zawodny, Milwaukee	x	x	x
	P. J. Niland, Milwaukee	x	x	x
	R. T. McCarty, Milwaukee	x	o	o
	A. G. Martin, Milwaukee	x	o	x
	A. J. Sanfelippo, Milwaukee	x	x	o
	D. M. Willson, Milwaukee	x	x	x
	M. C. F. Lindert, Milwaukee	o	o	o
	John M. Beffel, Milwaukee	x	x	o
	C. M. Schroeder, Milwaukee	o	x	x
	S. A. Morton, Milwaukee	x	x	o
	E. M. End, Wauwatosa	x	o	o
Monroe	S. D. Beebe, Sparta	o	o	o
	Harry Mannis, Sparta	o	o	o
	D. C. Beebe, Sparta	x	x	x
Oconto	H. A. Aageson, Oconto	x	x	x
	F. E. Zantow, Oconto	o	o	o
Oneida–Vilas	Marvin Wright, Rhinelander	x	x	x
	I. E. Schiek, Sr., Rhinelander	o	o	o
Outagamie	G. W. Carlson, Appleton	x	x	x
	H. T. Gross, Appleton	x	x	x
Pierce–St. Croix	P. H. Gutzler, River Falls	x	x	x
	O. H. Epley, New Richmond	o	o	o
Polk	L. O. Simenstad, Osceola	x	x	x
	V. C. Kremser, Amery	o	o	o
Portage	F. E. Gehin, Stevens Point	x	x	x
	R. H. Slater, Stevens Point	o	o	o
Price–Taylor	J. D. Leahy, Park Falls	x	o	x
	W. E. Niebauer, Phillips	o	o	o
Racine	G. J. Schulz, Union Grove	x	x	x
	R. J. Schacht, Racine	o	o	o
	L. O. Mastalir, Burlington	x	x	o
	J. D. Postorino, Racine	o	o	x
Richland	D. J. Taft, Richland Center	o	x	x
	R. E. Housner, Richland Center	x	o	o
Rock	R. A. Thayer, Beloit	x	x	x
	W. J. Mauermann, Beloit	o	o	o
	M. D. Davis, Milton	x	x	x
	J. D. Schroeder, Janesville	o	o	o
Rusk	L. M. Lundmark, Ladysmith	o	o	o
	Howard F. Pagel, Ladysmith	x	x	o
Sauk	J. F. Moon, Baraboo	x	x	o
	J. J. Rouse, Reedsburg	x	o	o
Shawano	A. A. Cantwell, Shawano	x	x	x
	H. C. Marsh, Shawano	x	x	x
Sheboygan	P. B. Mason, Sheboygan	x	x	x
	F. A. Nause, Sheboygan	o	x	o
Trempealeau–Jackson–Buffalo	R. L. MacCornack, Sr., Whitehall	x	x	x
	B. C. Dockendorff, Arcadia	x	x	x
Vernon	R. S. Hirsch, Viroqua	x	x	x
	L. F. Gulbrandsen, Viroqua	o	o	o
Walworth	E. D. Sorenson, Elkhorn	x	x	x
	E. D. Hudson, Lake Geneva	o	o	o
Washington–Ozaukee	E. C. Quackenbush, Hartford	x	x	o
	P. B. Blanchard, Cedarburg	x	o	o
Waukesha	M. J. Werra, Waukesha	x	x	x
	W. D. James, Oconomowoc	x	x	x
Waupaca	M. A. Borchardt, New London	o	o	o
	W. G. Arnold, Clintonville	x	o	o
Winnebago	R. H. Bitter, Oshkosh	o	o	o
	David Regan, Neenah	o	o	o
	George Schwei, Menasha	x	x	x
	Warren V. Hahn, Oshkosh	x	x	o
	J. P. Canavan, Neenah	o	o	x
Wood	R. W. Mason, Marshfield	o	x	x
	W. L. Nelson, Wisconsin Rapids	x	o	o
General Practice	E. J. Schneller, Racine	x	o	o
	C. G. Reznichek, Madison	x	o	o
Internal Medicine	R. N. Allin, Madison	o	o	o
	R. A. Frisch, Milwaukee	x	x	x
Neurology and Psychiatry	Harry Tabachnick, Milwaukee	x	x	o
	E. Madison Paine, Green Bay	o	o	o
Obstetrics and Gynecology	F. J. Hofmeister, Milwaukee	o	o	o
	W. O. Paulson, Eau Claire	o	o	o
Ophthalmology and Otolaryngology	E. J. Zeiss, Appleton	x	x	x
	H. C. High, Jr., Milwaukee	o	o	o
Orthopedics	D. W. McCormick, Fond du Lac	o	o	o
	F. G. Gaenslen, Milwaukee	x	o	o
Pathology	Gorton Ritchie, Milwaukee	x	x	x
	R. S. Haukohl, Milwaukee	o	o	o
Pediatrics	George H. Wegmann, Milwaukee	x	x	o
	E. H. Pawsat, Fond du Lac	o	o	x
Public Health	Milton Feig, Madison	o	o	o
	C. K. Kincaid, Madison	o	o	o
Radiology	W. T. Clark, Janesville	x	x	x
	R. L. Troup, Green Bay	o	o	o
Surgery	J. M. Sullivan, Milwaukee	o	o	o
	M. G. Rice, Stevens Point	o	o	o
Urology	J. W. Sargent, Milwaukee	x	x	o
	R. S. Irwin, Milwaukee	o	o	o

*Indented names are those of alternates.

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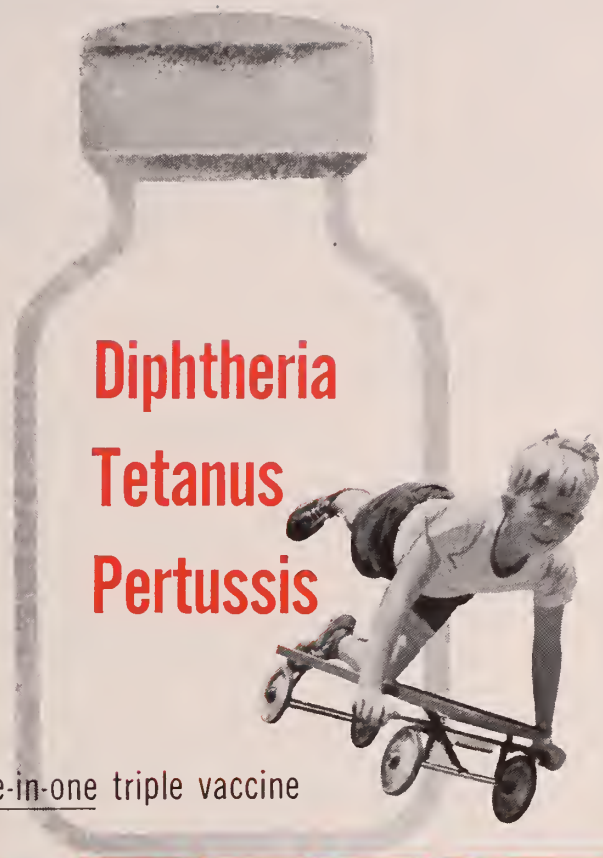

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A postgraduate course for non-radiologists on the "Application of Radioisotopes in Clinical Medicine" will be offered on four Thursdays, October 20 and 27 and November 3 and 10, from 10 a.m. to 12 noon at the Marquette University School of Medicine.

The course will include lectures and demonstrations on evidence for and use of radioactive iodine, phosphorus, gold, cobalt, and chromium and the diagnosis and therapy of diseases of the thyroid and blood, and various tumors.

Basic nuclear physics will be briefly considered, and the side effects of "atomic medicine" will be discussed.

The course is under the direction of Dr. Irving I. Cowan, director of the department of isotopes and assistant clinical professor of radiology.

Participating as lecturers will be: Dr. John S. Hirschboeck, dean of the School of Medicine; Dr. William W. Engstrom, associate professor of medicine; Dr. Carl W. Eberbach, clinical professor and director of the department of surgery; Dr. Roland S. Cron, clinical professor and director of the department of obstetrics and gynecology; and Mr. Frank Karioris, assistant professor of physics.

Tuition is $20 for the eight-hour course.

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Society Proceedings

Calumet

On August 9 members of the Calumet County Medical Society and their wives attended a dinner meeting at the country club at New Holstein. During the business session plans were discussed for the organization of the medical staff of Calumet Memorial Hospital. Special guests at the meeting were *Dr.* and Mrs. *James Knauf*, Neopit.

Polk

Dr. V. C. Kremser of Amery was host to the Polk County Medical Society when it met on July 21 at Indianhead Lodge, Balsam Lake. Guest speakers for the scientific portion of the program were members of the Nicollet Clinic in Minneapolis. Dr. Arthur Ide, Jr., discussed "Carcinoma of the Thyroid"; and Dr. William A. O'Brien spoke on "Observations on Transfusions." A round-table discussion followed the presentation of the papers.

Trempealeau–Jackson–Buffalo

Twenty members of the Trempealeau–Jackson–Buffalo County Medical Society met in Black River Falls on July 26. Following dinner at the Hotel Freeman, a scientific program was presented.

Wood

Three Marshfield Clinic physicians, Drs. Walter P. Quigley, Walter R. Kearney, and Joseph L. Ousley, spoke at the August 18 meeting of the Wood County Medical Society, which was held at the Hotel Charles, Marshfield. The doctors discussed the administration of radioactive substances in the diagnosis and treatment of thyroid disease.

Wisconsin Academy of General Practice, Southwestern Chapter

Physicians from Iowa, Lafayette, Grant, and Crawford counties met recently at Mineral Point to organize the Southwestern Chapter of the Wisconsin Academy of General Practice. Officers elected include: *Dr. N. A. McGreane*, Darlington, president; *Dr. R. D. Jackson*, Lancaster, vice-president; *Dr. G. W. Bair*, Platteville, secretary–treasurer; *Dr. W. D. Hamlin*, Mineral Point, delegate; and *Dr. C. H. Shields, Jr.*, Fennimore, alternate delegate to the state convention of the Academy.

The chapter agreed to have at least four scientific sessions a year, with talks by selected outside speakers and papers presented by members.

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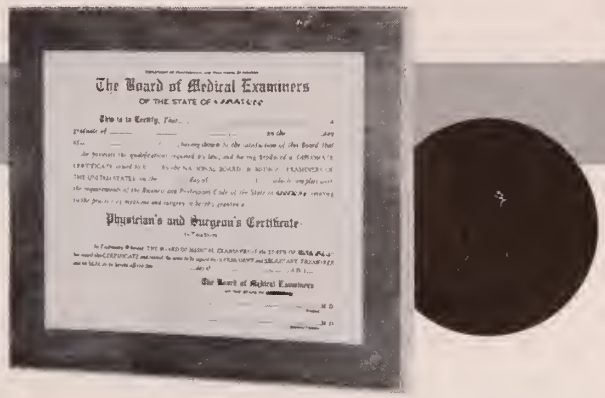

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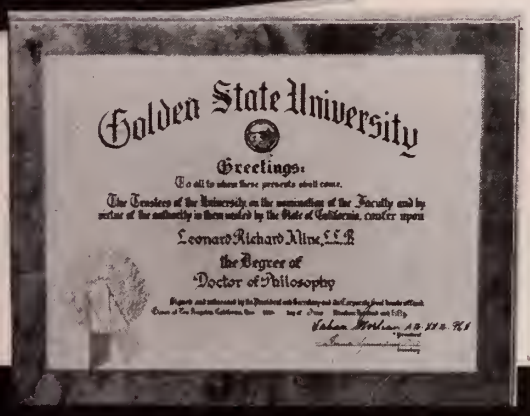

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News Items and Personals

New Physician in West Salem

Dr. Baldwin E. Lloyd has opened a practice in West Salem, where he will be associated with *Dr. R. H. Goedecke.*

Doctor Lloyd is a 1952 graduate of the University of Wisconsin Medical School. He interned at Passavant Hospital, Milwaukee, and spent a year in a general practice residency at the University of Colorado hospitals. During the past year he was a surgical resident at St. Joseph Mercy Hospital in Mason City, Iowa. He served as a naval officer in the Pacific theater during World War II.

Dr. F. X. Pomainville Honored

Dr. F. X. Pomainville of Wisconsin Rapids was appointed to the newly created office of "grand medicin" of the 40 et 8, Grande Voiture of Wisconsin, at the final session of the organization's state promenade in Milwaukee recently.

The grand cheminot (state executive committee) conferred the honor on Doctor Pomainville in recognition of his long years of service to local American Legion and 40 et 8 circles. He has been medicin of Wood County Voiture 1139 for many years and was one of the early commanders of his local American Legion post.

After the appointment had been voted, Doctor Pomainville was formally introduced and received a standing ovation. He was welcomed into state office in the legion honor society and fun organization by Earl Simpson, Tulsa, Oklahoma, national commander of the 40 et 8, and Arthur Minning, Watertown, Wisconsin's new grand chef de gare.

Oshkosh Physician Chairman of Heart Association Committee

Dr. Ray Wagner of Oshkosh has been appointed chairman of the Lake Winnebago Area Heart Committee of the Wisconsin Heart Association, an area which includes Calumet, Manitowoc, Fond du Lac, Sheboygan, Washington, and Ozaukee counties. The committee is responsible for developing the community service and public education programs of the Heart Association in these counties.

Doctor Edelblute Opens Office in Green Bay

Dr. Lyle H. Edelblute, x-ray diagnostician at Bellin Memorial Hospital, Green Bay, since March, 1954, has opened an office in the Minahan–McCormick Building for the practice of therapeutic radiol-

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ogy. The office is that formerly occupied by the late Dr. A. O. Olmsted.

Doctor Edelblute received his M. D. degree at the University of Kansas in 1945, and interned at Wisconsin General Hospital. For eight years he was in the Medical Corps of the Army. He took specialized training in x-ray at Walter Reed Hospital in 1947, 1948, and 1949. He is a diplomate of the American Board of Radiology and a member of the American College of Radiology.

He will continue his work at Bellin Hospital in addition to maintaining his new office.

Doctor Tverberg Returns to Mauston

After completing two years in military service, *Dr. M. S. Tverberg* has resumed his practice in Mauston. He had been stationed at Ulm, Germany, since last November and was discharged with the rank of captain.

Doctor Mastalir Resumes Burlington Practice

Dr. L. O. Mastalir, who has spent the last eight months in specialized study at the Jackson Clinic, Madison, and at Madison hospitals, has returned to practice in Burlington. In his clinic there, he is associated with Drs. *D. J. Baker* and Raymond Doyle.

Doctor Ashe Begins Practice in Michigan

Dr. Henry S. Ashe, who practiced in Mercer before being called into service in 1952, has now been released from service and has opened a practice in Ironwood, Michigan.

While in service, Doctor Ashe was stationed at Pensacola, Florida, and later at Cherry Point, North Carolina, as flight surgeon with the U. S. Marines.

Dr. E. C. Cary Receives Dale Carnegie Citation

Reedsville physician, *Dr. Erwin C. Cary,* was cited by Division 2 of the Dale Carnegie Club International at Milwaukee on August 7.

The citation which he received read:

"Erwin C. Cary, M. D., has been active in DCCI work in Wisconsin since its infancy; his support and interest were especially valuable in both district and division activities.

"The medical profession is known for its demands as far as 'job hours' are concerned, for a doctor is on call both day and night . . . therefore, the time donated by Dr. Cary to DCCI takes on an even greater significance. His untiring and unselfish efforts did much for the sound establishment of Division No. 2 of DCCI.

"The fact that he is and has been active in DCCI work, and that he has held both district and division offices (past division governor) proves, of course, his sincere interest in the practice and the fostering of the art of good human relations."

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Dr. L. L. Larson to Take Specialized Training

Dr. Lawrence L. Larson has left his general practice in Hales Corners to take specialized training in radiology at St. Luke's Hospital in Milwaukee. His practice is being taken over by *Dr. Edward J. Beil,* who had been practicing at Land O'Lakes.

Doctor Gmeiner Has New Associate

Dr. Ernest J. Miller, a 1948 graduate of Marquette University School of Medicine, has become associated with *Dr. James E. Gmeiner* in the practice of orthopedic surgery at Appleton. Doctor Miller served his internship at St. Mary's Hospital, Milwaukee, and took orthopedic training at the Veterans Hospital at Wood and at Children's Hospital, Milwaukee, completing his training in 1953. Then he spent two years on active duty with the armed forces at Fort Jackson, Columbia, South Carolina, where he served as assistant to the chief of orthopedic services.

Chetek Honors Doctor Adams

Dr. R. W. Adams, Chetek physician for more than a quarter century, was honored by the people of his community and his professional colleagues on July 24.

A Doctor Adams recognition day, during which the churches and almost every organization in the community participated, was held. There was a public reception in the afternoon and a testimonial dinner in the evening. Proceeds from the dinner tickets are to be used in equipping a Doctor Adams room at both Lakeside and St. Joseph's hospitals at Rice Lake.

THIRD AND TWELFTH DISTRICTS NEWS

Dr. Jay Keepman Opens Office in Madison

Dr. Jay P. Keepman, a graduate of the University of Wisconsin Medical School, has begun a general practice in Madison. He is sharing offices with *Drs. R. S. Gearhart* and *J. G. Van Gemert.* Doctor Keepman served his internship at St. Mary's Hospital, Duluth, Minnesota.

Doctor Boner to Leave Madison

Dr. Albert J. Boner, a Madison psychiatrist, left at the end of August to practice his specialty in Los Angeles, California. In addition to maintaining his private practice, the doctor was an instructor in clinical medicine at the University of Wisconsin Medical School from 1928 to 1942, when he entered army service during World War II. He was discharged as a major from the Army in 1945 and returned to his Madison practice in 1946.

Doctor Ylitalo Joins Quisling Clinic

Dr. William H. Ylitalo, who received his pediatric training at the Mayo Clinic, Rochester, Minnesota, recently joined the Quisling Clinic, Madison. He was graduated in 1945 from the Minnesota School of Medicine. From 1945 to 1947, he served in the navy and was stationed at Guam, where he was senior

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*Farley, W. J.: Oxytetracycline in Pediatrics. Internat. Rec. Med. *168*:140 (March) 1955.

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medical officer. He entered private practice at Hibbing, Minnesota, after his navy discharge. For the past three years he has been at the Mayo Clinic, where he received his masters degree in pediatrics.

Cambridge Has New Doctor

Dr. James Nora, who recently completed his internship at the City of Detroit Receiving Hospital, has opened an office for the practice of medicine in Cambridge. After graduating from high school in Chicago, Doctor Nora served from 1945 to 1947 in the armed forces. He received his bachelor's degree from Harvard and his medical degree from Yale University School of Medicine.

Doctor Rueckert Opens Office in Portage

Dr. Ray R. Rueckert, assistant professor of preventive medicine at the University of Wisconsin Medical School, resigned at the end of the summer session in order to open an office for private practice in Portage. A 1939 graduate of the Medical School, he served his internship at Kansas City Research Hospital. With the exception of 43 months spent in the Naval Medical Corps during World War II, Doctor Rueckert had been a staff member of the University Department of Student Health and Infirmary since 1940.

SOCIETY RECORDS

New Members

E. J. Beil, Hales Corners.

E. C. Bobo, Veterans Administration Hospital, Wood.

M. W. Biljan, 7207 West Greenfield Avenue, West Allis.

E. M. Bremer, 208 East Wisconsin Avenue, Milwaukee.

J. R. Cornfield, 5022 West Hampton Avenue, Milwaukee.

N. C. DeLeo, 3075 North 35th Street, Milwaukee.

T. H. Leitschuh, Veterans Administration Hospital, Wood.

R. S. Stern, 1420 South 70th Street, West Allis.

R. O. Sternlieb, 3335 North 44th Street, Milwaukee.

R. J. Fogle, 312 Seventh Avenue, Racine.

E. P. Lauerman, 312 Seventh Avenue, Racine.

R. A. Hines, 2132 Maywood Avenue, Middleton.

M. Pinson Neal, Jr., 1300 University Avenue, Madison.

C. A. Doehlert, Jr., 1922 University Avenue, Madison.

B. W. Claypool, Jr., Waupaca.

J. O. Cales, Monroe Clinic, Monroe.

E. G. Schulz, 237 Wisconsin Avenue, Waukesha.

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Salvatore Megna, Tucson, Arizona, to 4201 North Woodburn Street, Milwaukee.

P. J. Malloy, Hines, Illinois, to 425 East Wisconsin Avenue, Milwaukee.

R. G. Mendez, Milwaukee, to 12462 Brookhurst, Garden Grove, California.

R. A Hanson,** Milwaukee, to Box 394, Gunter Air Force Base, Montgomery, Alabama.

E. L. Tharinger, Naples, Florida, to 6300 West Wisconsin Avenue, Milwaukee.

R. L. Schwab, Milwaukee, to Theda Clark Memorial Hospital, Neenah.

J. D. Steele, Jr., Milwaukee, to Veterans Administration Hospital, San Fernando, California.

A. E. Kuehn,** Fort Sam Houston, Texas, to A.P.O. 154, % Postmaster, New York, New York.

E. J. Miller, Columbia, South Carolina, to 103 West College Avenue, Appleton.

A. B. Weinstein,** Fort Sam Houston, Texas, to Box 15, William Beaumont Army Hospital, Fort Bliss, Texas.

Marvin Glicklich, Milwaukee, to Children's Memorial Hospital, 707 Fullerton Avenue, Chicago, Illinois.

Lucille B. Glicklich, Milwaukee, to 4826 West Warner Street, Chicago, Illinois.

A. L. Settimi, Milwaukee, to Casita Hospital, Indio, California.

R. E. Holzgrafe, Milwaukee, to Veterans Administration Hospital, McKinney, Texas.

J. J. Klobucar, Fort Riley, Kansas, to 414 East Walnut Street, Green Bay.

J. A. Boren, Rochester, Minnesota, to 1510 Main Street, Marinette.

H. W. Harris,** Aurora, Colorado, to 859 LaGrand, Salt Lake City, Utah.

E. J. Kiefer, Wauwatosa, 105 North Eighth Street, Boise, Idaho.

P. P. Meighan,** Whitewater, to U. S. Army Hospital, Fort Belvoir, Virginia.

D. E. Olson, Denver, Colorado, to 2148 N. E. 20th Avenue, Portland, Oregon.

Roy Hong,** Wild Rose, to 35th Tac. Hospital, F.E.A.F., A.P.O. 328, San Francisco, California.

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MARRIAGES

Dr. William W. Chandler, Appleton, to Miss Paula Ann Cornish, Ft. Atkinson.

DEATHS

Dr. Chris P. Arnoldussen, 44-yr old

In 1949, Doctor Arnoldussen was chosen the most physician who was fatally injured in an automobile accident while en route to the hospital at New London, Wisconsin, died on July 15. The accident occurred just after he had delivered a baby in a car in front of his home and was driving behind the car to the hospital.

Doctor Arnoldussen was born on May 18, 1911. He was graduated from Marquette University School of Medicine in 1937; completed his internship at St. Agnes Hospital, Fond du Lac; and in 1938 established his practice in Fremont.

In 1949, Doctor Arnoldussen was chosen the most valuable citizen of Fremont and was awarded a medal by the community.

He held membership in the Waupaca County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association and had served as president of his county society. He was on the staff of the New London Community Hospital.

His wife, Cecile; his mother; a daughter; three sons; two brothers; and four sisters are the survivors.

Dr. Felix Schmit, Milwaukee physician for fifty years, died at his home on July 24. Born on February 7, 1873, he was 82 years of age at the time of his death.

A native of Luxembourg, Doctor Schmit came to Milwaukee in 1886. He received his medical degree from Milwaukee Medical College in 1900 and interned at Milwaukee County Hospital. He did postgraduate work at the University of Berlin and the University of Vienna.

Doctor Schmit was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical

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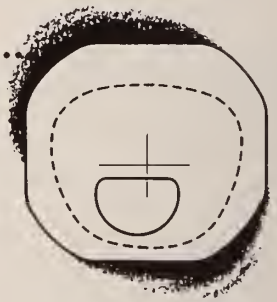

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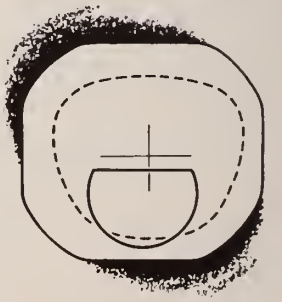
The P-28



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Association. He was on the staffs of St. Michael, St. Joseph's, and St. Anthony's hospitals.

A sister, Miss Celestine Schmit, and a brother, Dr. Louis Schmit, both of Wauwatosa, survive.

Dr. Sylvester J. Driessel, who practiced in West Bend and Barton, passed away on July 25. He was 69 years of age.

Doctor Driessel was born at Hilbert, Wisconsin, on November 3, 1885. He graduated from the Wisconsin College of Physicians and Surgeons at Milwaukee in 1907 and interned at St. Joseph's Hospital in Milwaukee. He began his practice of medicine in Barton, and in 1922 joined Dr. D. Webster Lynch in West Bend. Later Doctor Driessel took over the West Bend practice completely; and, at the time of his death, he was associated with his son, Dr. Richard, in the operation of the West Bend Clinic.

He held membership in the Washington-Ozaukee County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his wife, Laurette; four children, Dr. Richard of West Bend, Maj. Sylvester H., with the air force in Landstuhl, Germany, and Mrs. Donald Carey and Mrs. Jerome Holl, both of Fort Atkinson; six grandchildren; and a sister, Mrs. Malcolm Chinook of Milwaukee.

Dr. David M. Gallaher, Appleton general practitioner, passed away on July 30. Born on March 27, 1896, he was 59 years of age at the time of his death. He had retired in June, 1954.

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One tablet one-half hour before meals, and 1 to 2 tablets at bedtime.

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Methscopolamine bromide ..... 1.25 mg.

Dosage:
While the dosage and indications are the same as for the full-strength tablets, this tablet allows greater flexibility in regulating the individual dose, and may be employed in less severe gastrointestinal conditions.

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Both strengths in bottles of 100 tablets; the full-strength tablets also available in bottles of 500.

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Each 5 cc. (approx. 1 tsp.) contains:
Phenobarbital ..... 8.0 mg. (⅛ gr.)
Methscopolamine bromide ..... 1.25 mg.
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Dosage:
1 to 2 teaspoonfuls three or four times daily, depending upon requirements in the individual patients.

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Doctor Gallaher was born in Warren, Illinois. His medical education was obtained at the University of Iowa Medical School, from which he graduated in 1923. He interned at Miller Hospital, St. Paul, and served his residency at Barnes Hospital, St. Louis, Missouri. During World War I he served in the Army Engineer Corps. Before coming to Appleton in 1927, he had practiced at Kaukauna. In Appleton, he was associated with Drs. J. B. MacLaren and R. V. Landis. He had served as Northwestern Railroad and Milwaukee Railroad surgeon for the Appleton area since he began his practice.

Organized medical groups with which Doctor Gallaher was affiliated were the Outagamie County Medical Society, of which he had served as president; the State Medical Society of Wisconsin; the American Medical Association; the American College of Surgeons; and the Wisconsin Society of Obstetrics and Gynecology. He was on the staff at St. Elizabeth's Hospital in Appleton.

He is survived by his wife, Marian; a son, Dr. David M., Appleton; a daughter, Dr. Marian E., Los Angeles, California; three brothers; and one sister.

Dr. Edwin Henes, Jr., retired Milwaukee physician, died at his home on July 25 at the age of 70. A specialist in internal medicine, he had practiced in Milwaukee from 1919 until the time of his retirement in 1935.

Born in New York City on January 28, 1885, he received his medical degree from Columbia University in 1910 and interned at German Hospital, New York. From 1910 to 1917 he practiced in hospitals in New York. He served in the Army Medical Corps during World War I, after which he established his practice in Milwaukee.

A member of county, state, and national medical associations, Doctor Henes was also a nonresident fellow of the Institute of Medicine of Chicago and a charter member of the Milwaukee Internists Club. He was a past president and trustee of the Milwaukee Academy of Medicine.

Surviving Doctor Henes are his wife, Irma; a daughter, Mrs. Arthur Young, Milwaukee; and a sister, Mrs. Carl Eggers, New York City.

Dr. Edwin B. Gute, who had practiced in Whitefish Bay for 30 years, died at a Milwaukee hospital on July 15. He was 58 years of age.

He was born on February 27, 1897, in Milwaukee. His medical degree was obtained from Rush Medical School in 1925, and he interned at Milwaukee Children's Hospital and Milwaukee Hospital "The Passavant."

In 1916, he served in the U. S. cavalry on the Mexican border. During World War I he was a first sergeant in the 120th field artillery, 32nd division, and in World War II served in the navy, being discharged as a commander.

He was health commissioner in Whitefish Bay from 1927 to 1943 and had been health commissioner of Fox Point since 1933 and of Bayside since 1953.

He was chairman of the Milwaukee County Association of Suburban Health Commissioners.

Doctor Gute's professional affiliations included the Milwaukee Academy of Medicine, the American Public Health Association, the American Association of School Physicians, the Medical Society of Milwaukee County, the State Medical Society of Wisconsin. and the American Medical Association.

He is survived by his wife, Fredricka; a son, Daniel, Whitefish Bay; a daughter, Mrs. Sally Clarke, Cleveland; two brothers; and a sister.

Dr. Thomas H. Lorenz, Madison, suffered a fatal heart attack while leading his 135th Medical Battalion, a Madison unit of the 32nd National Guard Division, in parade on June 18.

Thirty-five years of age, Doctor Lorenz was born on February 26, 1920. He was graduated from the University of Wisconsin Medical School in 1944; interned at Evanston Hospital, Evanston, Illinois; and served a residency in internal medicine at University Hospitals, Madison.

During a three-year period of service in the medical corps, Doctor Lorenz was stationed in the European theater of operations for 18 months during the German occupation. In 1947 he joined the guard division at Madison. He was promoted to major in 1950 when he assumed command of the 135th battalion. His father, Col. William F. Lorenz, was chieftain of the same battalion during the unit's active duty in World War II. In March, 1954, the younger Doctor Lorenz was promoted to the rank of lieutenant colonel. On the day of his death, a Milwaukee ambulance company that had been trained by him won the Eisenhower trophy, highest award given in a year to guardsmen for proficiency and achievement in all aspects of military training.

Following his career in the Army, Doctor Lorenz became associated with the medical school at the University of Wisconsin and University Hospitals, attaining the rank of assistant professor of medicine. Here again he was following in the footsteps of his father, who also had served in the medical school, as head of the psychiatric department. The younger Doctor Lorenz also served as a consultant in psychosomatic medicine at the Veterans Administration Hospital, Madison.

He was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his wife, Alta Mae; two children, Tom, Jr., and Susan; his father, Dr. W. F. Lorenz, Sr., who is retired and living in Gordon, Wisconsin; and three brothers, William F., Jr., Paul K., and Joseph D., all of Madison.

Dr. Carl F. Siefert, 76-year-old Milwaukee general practitioner, died on July 19. He had practiced in Milwaukee for 43 years.

He received his medical degree from Rush Medical School in Chicago. He had been on the staff at Deaconess Hospital and also practiced at Mount Sinai Hospital. During the last seven years he had been in semiretirement.

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

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Brown, H. W.: J. Pediat. 45:419, 1954.

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Surgery of Colon & Rectum, One Week, October 17
General Surgery, Two Weeks, October 3; One Week, October 17
Gallbladder Surgery, Ten Hours, October 24
Thoracic Surgery, One Week, October 3
Esophageal Surgery, One Week, October 10
Basic Principles in General Surgery, Two Weeks, September 26
Fractures & Traumatic Surgery, Two Weeks, October 17
GYNECOLOGY—Office & Operative Gynecology, Two Weeks, November 28
Vaginal Approach to Pelvic Surgery, One Week, November 7
OBSTETRICS—General & Surgical Obstetrics, Two Weeks, November 7
MEDICINE—Two-Week Course, September 26
Electrocardiography, One-Week Advanced Course, September 19
Electrocardiography & Heart Disease, Two-Week Basic Course, October 10
Gastroscopy, Forty-Hour Basic Course, November 7
Dermatology, Two Weeks, October 17
RADIOLOGY—Clinical & Didactic Course, Two Weeks, October 3
Clinical Uses of Radiosotopes, Two Weeks, October 10
PEDIATRICS—Clinical Course, Two Weeks, by Appointment
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Survivors include his wife, Anna; two sons, Fred H., Whitefish Bay, and Carl F., Jr., Shorewood; and a sister, Mrs. Mathilda Puelicher, Milwaukee.

Dr. Walter A. Ford, who formerly practiced at the Sheboygan Clinic, died at his office in Houston, Texas, on July 13. He was 67 years of age.

An eye, ear, nose, and throat specialist, Doctor Ford received his medical degree from Loyola University; did postgraduate work in ophthalmology at the University of Illinois; and served as resident surgeon of the Illinois Eye and Ear Infirmary at Chicago from 1919 to 1921. Two years later, he came to Sheboygan, where he remained until 1945, when he resigned and moved to Houston, Texas, because his health required a warmer climate.

During World War II, he served at several camps in Texas. He received his army retirement in 1944, when he resumed his Sheboygan practice for a short time before moving to Texas.

Doctor Ford was a former member of the Sheboygan County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his wife, Marietta, and three sons, Dr. Donald of New Orleans and Douglas and Walter, Jr., both of Houston.

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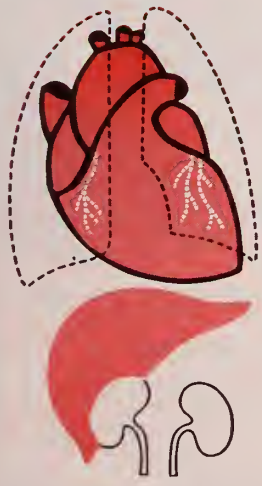

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2. There must be a re-affirmation of *service benefits* as the cachet of Blue Shield operation.

3. Blue Shield must achieve *national stature* and operate on a national scale, without sacrificing local community control.

4. It must preserve a *balanced enrollment* among the various classes of the population so it can cover the lowest economic groups at a community rate they can afford.

5. Blue Shield must win *organized medicine's support* nationally to the same degree that it has won doctor support locally.

6. It must *identify itself* with the individual physician—not as "just another insurance company" but as the doctor's own mechanism for providing service to everybody.

7. Blue Shield must find ways to give the general *public* a more conscious sense of *participation* in the movement.

The future of Blue Shield—indeed, the future of America's free system of medical practice—depends on the willingness of the American Medical Association to recognize Blue Shield as the profession's own creation.

Medicine is not in the insurance business; but it *is* in the business of providing medical service. Blue Shield was conceived by the profession to make such service—not cash—available.

Medicine's national association owes it to itself to give the same guidance and support to Blue Shield that most of its state and local societies give the plans within their jurisdictions. . .

There is, by the way, as great a danger in the doctor's becoming too exclusive a proprietor of Blue Shield as in his ignoring it altogether. We encounter too often the physician who says, in effect, "This is my plan, and I will run it to suit myself." Let him remember that it's the subscriber who pays the bills; and the subscriber is interested in Blue Shield not as "the *doctor's* plan" but as the *patient's* plan, created and serviced by doctors.

The public relations problem of the Blue Shield is essentially one of *identification.* Blue Shield is approved by organized medicine, of course; yet few private physicians seem to appreciate that their fate is bound up inextricably with that of Blue Shield. . .

Either Blue Shield—with all its accomplishments, its shortcomings, and its potentialities—is the expression of the American medical profession, or it is not. If it *is*, then let's have the national leadership Blue Shield so urgently needs. If it is *not*, then medicine had better get itself another program—and soon!

Blue Shield must gain a clear identification with the American community. People have confidence in the plan because they have confidence in America's doctors. The profession can't afford to forfeit that trust.

Blue Shield carries the burden of destiny not only for private medical practice but possibly for our free society itself. It merits the best that American medicine can give it—in vision and in leadership.

---

* By James E. Bryan, former executive secretary of Westchester County (N. Y.), New York County, and New Jersey State medical societies, and recently administrator of the New Jersey Blue Shield Plan. Reprinted by permission from May, 1955, *Medical Economics.*

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FOR SALE: Abrahamson Sedimentation Tube outfit with base and assembly. Address replies to Box 600 in care of the Journal.

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Volume 54 OCTOBER 1955 Number 10

Repair of the Surgically Injured Ureter

By T. H. McDONELL, M. D.
Marshfield

SURGICAL injuries of the ureter are surprisingly common, they have been produced by the most skillful surgeons, and their occurrence is always sudden and unexpected. The surgeon who inadvertently divides a ureter which is drawn out of its normal bed and enveloped by a dense wall of fibrous tissue is usually blameless. But he is nonetheless shattered by the accident and, for that reason, urologic consultation, if available, is probably wise. The consultant is at home with handling of the ureter, is familiar with the repair, realizes the principles of preservation of function, and is unhampered by the surgeon's understandable chagrin.

Type of Injury

Ureteral trauma usually occurs during pelvic surgery, particularly during the course of complicated gynecologic procedures.[1, 2] The injury, therefore, is low in the ureter. This has the obvious disadvantage of limiting exposure during attempts at repair. However, the low level of injury does leave a long proximal segment of ureter, which facilitates transplantation when necessary. Usually only one ureter is injured, but in about one-sixth of the patients both are involved. The exact nature of the ureteral trauma may take many forms. The ureter may have been enveloped by a single ligature. A suture ligature may have perforated the lumen. The ligature may have been so placed in close apposition to the ureter that resulting angulation proves obstructive. The ureter may have been cleanly severed, or only a part of its wall may have been excised. The ureteral blood supply may have been so compromised that necrosis occurs. On occasion, a considerable length of the ureter may have been crushed or excised.

Symptoms

The nature and severity of the symptoms depend upon the time of recognition, the degree of obstruction, and the presence or absence of extravasation. Bilateral complete obstruction will, of course, produce total anuria and, soon thereafter, the picture of uremia. Unilateral incomplete obstruction will usually result in a slowly developing hydronephrosis. It was formerly felt that unilateral complete obstruction would be immediately followed by total cessation of urine formation and a quiet atrophy and death of that kidney. It seemed certain that when intrapelvic pressure equaled intraglomerular pressure, urine production must cease. However, as a matter of actual fact, a goodly number of these totally obstructed kidneys continue to function and go on to a hydronephrotic state. This apparent enigma was solved by Hinman's concept of pyelovenous, pyelotubular, and pyelolymphatic backflow.[3] The urine makes its way from the pelvis back into the general circulation via these outlets. The kidney literally secretes into its own circulation.

An uncomplicated hydronephrosis usually produces an ill-defined flank discomfort and only occasionally outright pain. The symptom complex may be entirely gastrointestinal in character. Occasionally, there may be no untoward symptoms at all. The appearance of infection is of grave consequence. Fever and chills are prominent. Flank pain and tenderness are exaggerated. An acute hydronephrosis which becomes infected usually means rapid renal destruction.

When ureteral continuity is interrupted, a fistula has been produced and extravasation results. The urine will usually find its way along the path of previous surgical dissection and a vaginal or abdominal urinary fis-

tula will result. A hidden extravasation, if extraperitoneal, may manifest itself as a bulging area in the flank. If intraperitoneal and infected, a frank peritonitis results. However, the peritoneum tolerates a sterile urine well; and in these cases some time may pass before the diagnosis becomes evident.

Diagnosis

Ideally, one hopes to recognize the injury at surgery. However, a lapse of several days is often the case. An excretory urogram is the logical first step. There will probably be insufficient concentration on the affected side for interpretation, but the urogram will localize the side of injury and also ascertain the presence of a normal opposite kidney. In the determination of whether a fistula is vesical or ureteral in origin, one may inject indigo carmine into the bladder. Assuming the ureteral orifices are normally continent, the dye will fail to appear in the fistulous tract in the case of ureteral injury. Cystoscopy with the passage of a ureteral catheter and retrograde pyelography should then be carried out. The ureteral catheter may successfully bypass the site of injury. More likely, it will meet an impassable obstruction at that point. The catheter may leave the ureter and injection will demonstrate extravasation of the contrast medium or, finally, it may follow the fistulous tract out of the body, as for example into the vagina.

Repair

If the surgeon is fortunate enough to recognize the ureteral injury at the time of surgery, repair can be carried out immediately. Ureteral continuity can usually be reestablished with facility. Rarely, the patient's condition may be so grave that simple ligation of the proximal stump is carried out. When the injury is recognized late, the decision between direct attack on the injured area or initial diversion of the urinary stream as by nephrostomy must be made. This is always an individual matter, but in general one should make a direct approach to the injured area if it is felt that there is a chance for definitive repair.

The type of repair will be governed by the level of the injury, the nature of the trauma, the length of the involved segment, and the amount of surrounding reaction. If one is fortunate enough to bypass successfully the site of obstruction cystoscopically, the catheter should be left indwelling. The fistula, if present, will often heal in three or four days and treatment will be complete. If open surgical attack is to be made, either an extraperitoneal approach via a Gibson incision or a transperitoneal approach is satisfactory. If the latter is elected, the area should be drained extraperitoneally. In the case of a ligature occluding the ureter, simple deligation is curative. Moore[4] advocates cystoscopy and manipulation with a ureteral catheter on the operating table. This facilitates identification of the site of trauma; and when the obstruction is relieved, the catheter can be passed to the renal pelvis, thereby assuring patency of the ureter. The catheter can be left indwelling for a few days as a splint.

In the event of a completely severed ureter, direct ureteroureteral anastomosis is the procedure of choice if both ends are free and viable. Exact approximation is recommended. I do not approve of the end-in-end anastomosis in which the proximal segment is telescoped into the distal segment. Absorbable sutures must be used under no tension whatsoever, and the urinary stream must be diverted. Creevy[5] makes a linear slit in the ureter below the injury and passes a catheter up to the pelvis. This both diverts the urine and serves as a splint. It is essential that the end of the catheter be properly placed so as to drain the pelvis completely. It should be of the proper size to fill the ureteral lumen snugly and should be securely anchored in position. Moore[4] inserts catheters into the ureter above the injury and directs one up to the pelvis and another down to the bladder.

Simple ligation of the proximal ureter, thereby sacrificing the kidney, has been done by many surgeons. This has its disadvantages. The kidney may fail to atrophy and become hydronephrotic as discussed previously. The ligature may slip, with resulting extravasation. Furthermore, palpation of an anatomically normal opposite kidney does not assure its functional normality.

When end-to-end anastomosis is not feasible, there are several alternatives. Among the most satisfactory is ureteroneocystostomy. If ureteral length is adequate, transplantation of the proximal ureter into a new bladder opening is simply done; and tunneling through the bladder muscle usually minimizes reflux.

If a considerable length of ureter has been compromised, there are several further alternatives. If the defect is not too great,

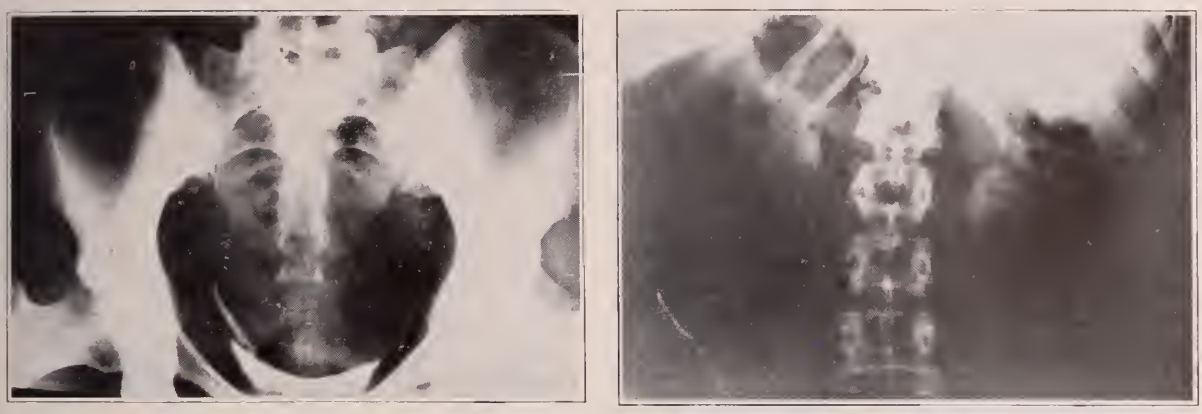

Fig. 1—Case No. 1. (Left) March 2, 1955. Ureteral catheter and contrast medium obstructed at level of ligature about ureter. (Right) April 21, 1955. Return to normal function after deligation.

mobilization of both ends of the ureter will sometimes bridge the gap. If the intrinsic blood supply in the ureteral wall is not too vigorously stripped, there should be no difficulty with necrosis. The Baori operation[6] is an ingenious device for gaining ureteral length. A bladder flap is elevated, formed into a tube, and joined to the proximal ureter. Reported results with this procedure have been excellent. Transuretero-ureteral anastomosis has been done by Higgins and others, but most urologists would hesitate to jeopardize a normal ureter for the benefit of an already damaged one. Uretero-intestinal transplantation is rarely indicated because of the ever-present danger of contamination and obstruction at the anastomotic site. However, in the occasional case, it may be the most satisfactory solution. Cutaneous ureterostomy is a generally unsatisfactory procedure in the case of ureteral injury and should be reserved as a last resort. Substitution of an isolated ileal segment for the extensively damaged ureter has been successfully accomplished on dogs by Davids and Lesnick[7] and has definite possibilities for the future.

Ureterostomy and particularly nephrostomy are of value in the case of bilateral injury. The treatment of bilateral complete ureteral obstruction is unilateral nephrostomy. One functioning kidney can sustain life nicely and get the patient over the critical period. Hinman[3] has demonstrated that a kidney can be totally obstructed for a period of three weeks or longer and still regain excellent function. Therefore, there is no immediate necessity for bilateral surgery. Finally, nephrectomy is occasionally the procedure of choice. It always damages a urologist's soul a little to remove a kidney that has the capacity for normal function. However, in the case of an aged patient who has had extensive pelvic surgery, particularly cancer surgery, and in whom an opposite normal kidney is present, a nephrectomy is sometimes the quickest, surest, and least debilitating course of therapy.

Prevention

How can one avoid these ureteral injuries? It seems likely that most surgeons are aware of the proximity of the ureters when doing pelvic surgery, but find themselves in trouble on occasion in spite of that knowledge. Often they have no suspicion of the accident until several days after surgery. There is probably an irreducible minimum of ureteral complications that one must accept and learn to live with. The only concrete step that seems worth while is the passage of ureteral catheters preoperatively whenever difficult pelvic surgery is anticipated.

Case Presentations

Case 1—Mrs. E. D., age 25, underwent a cesarean section because of a cephalopelvic disproportion. A bicornate uterus was found with the pregnancy in the right cornu. At surgery, a tear in the transverse uterine incision extended along the uterine artery beneath the bladder flap. The area was sutured with interrupted chromic catgut suture ligatures. Moderate right flank pain was noted on the sixth postoperative day. Excretory urography revealed failure of concentration on the right. Cystoscopy was done the following day, and a ureteral catheter was obstructed at 4 cm. on the right. The contrast medium also failed to bypass the obstruction. On the eighth postoperative day, through a Gibson extraperitoneal approach, the dilated

Fig. 2—Case No. 2. KUB intravenous pyelogram and left retrograde pyelogram. Note catheter free in pelvis, extravasation of contrast medium, and dilatation above level of injury.

ureter was identified near the iliac bifurcation. The ureter was followed inferiorly to the point of obstruction, where a chromic suture was divided and removed. The dilated proximal ureter promptly decreased in size. Of interest is the facility with which the dissection was carried out. Although the exploration was done on the eighth postoperative day, adhesions were not particularly troublesome. A small linear incision was made in the ureter above the site of injury, and a ureteral catheter was passed upward into the pelvis and inferiorly into the bladder. A drain was brought out through the incision, and at cystoscopy the ureteral catheter was drawn out through the urethra and anchored to a Foley catheter. The postoperative recovery was generally uneventful. In future cases, the ureteral catheter will probably be inserted cystoscopically in surgery as advocated by Moore. This would eliminate the incision into the ureter.

Case 2—Mrs. A. N., age 57, entered with a history of severe vaginal bleeding. Her admission hemoglobin was 3.6 Gm., and the red blood cell count was 1,760,000. The diagnosis of squamous cell carcinoma of the cervix, stage I, was established. Supportive treatment, as well as a course of x-ray therapy, was given. Two months later a Wertheim hysterectomy was performed. Ureteral catheters were inserted preoperatively. The patient sustained two postoperative wound eviscerations. On the eighth postoperative day urinary drainage per vagina was noted, and indigo carmine administered intravenously appeared in the vagina. Twenty days later a KUB intravenous pyelogram revealed dilatation of the left kidney and ureter and a normal right upper tract. At cystoscopy, a left ureteral catheter met a partial obstruction at 4 to 5 cm. and then passed out of the ureter to lie free in the pelvis. Injection of contrast medium confirmed the extravasation, and indigo carmine appeared promptly in the vagina. When the patient's condition permitted further surgery, a left nephrectomy was performed. The final result was excellent, and the patient remains well nine months later.

Summary

1. Ureteral injuries are common, and a review of the methods of diagnosis and repair is considered worth while.

2. The various types of injuries are described.

3. The nature and severity of the symptoms depend upon the promptness of recognition, the degree of obstruction, and the presence or absence of extravasation and infection.

4. The principles and methods of repair are presented.

5. Means of prevention are discussed.

6. Two cases are summarized.

Marshfield Clinic.

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The Role of the Anesthesiologist in the Management of Intractable Pain*

By JOHN J. BONICA, M. D.**
Tacoma, Wash.

"Pain is perfect misery, the worst of all evils;
And, excessive overturns all patience."

THE complaint of Milton in Paradise Lost[1] has, without a doubt, been uttered by human lips throughout the ages, for pain is as old as mankind, and perhaps even older. There is reason to believe that it is inherent to any life linked with consciousness.[2] Certainly there is evidence that man has been afflicted with this evil since his beginning, for as the records of every race are examined, one finds testimonials to the omnipresence of pain. On Babylonian clay tablets, in papyri written in the days of the pyramid builders, in Persian leathern documents, in inscriptions from Mycenae, on parchment rolls from Troy, and in records all down through the ages, in every civilization, in every culture, are found prayers, exorcisms, and incantations, which bear testimony to the dominance of pain. The unearthing of prehistoric human skeletons has added millions of years to man's recorded history of several millenia, and with it our knowledge of pain has been thrust back into the dark chasm of time, back into the eons, for many of these bones were indelibly stamped with signs of painful diseases, giving us evidence as to how early were the beginnings of man's *via dolorosa.* "Were we to imagine ourselves," wrote the French surgeon Daetigus, "suspended in timeless space over an abyss out of which the sounds of revolving earth rose to our ears, we would hear naught but an elemental roar of pain uttered as with one voice by suffering mankind."[2]

Pain without a doubt has been one of the greatest factors which has affected the course of human events, for there has been scarcely any man, great or small, who has escaped its throes. As classical authors relate the lives of the heroes, medieval chronicles tell the legends of saints, and biographers write of philosophers, artists, soldiers, inventors, scientists, reformers, *et al.*, invariably one of the chapters of these "greats" is entitled "Pain." It is therefore natural that since its beginning mankind should have engaged its energies to obviate such an evil force, and as long as pain has existed there have been efforts to find means of controlling it. Its management has for all times taxed the diagnostic acumen and therapeutic skill of physicians.

Not infrequently solution of this problem is only possible by the concerted effort of the patient's doctor and a number of specialists who contribute their individualized skills toward a common goal. Among this group is the anesthesiologist, who is often requested to lend his knowledge and technical skill to aid in the problem. In view of the fact that in some quarters there are differences of opinion as to what can be contributed by the anesthesiologist to the solution of this problem, it may be of benefit to discuss the proper role of this specialist in the management of intractable pain. Before doing so, however, it is necessary to mention briefly some fundamental concepts of pain.

What Is Pain?

Most people know what is meant by the word "pain," but have great difficulty in defining it. This is because pain is a highly personal affair, entirely subjective in nature, and often a complex physiopsychologic phenomenon which defies laboratory study.[2] At the present time, it is generally agreed that pain is always a combination and integration of two components: *pain perception* and *pain reaction.*[3] The perception of pain, like the perception of other sensations such as temperature and touch, is a neurophysiologic process accomplished by means of relatively simple and primitive neural receptive

* Presented at the One Hundred and Fourteenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, May 4, 1955.

** Director of the Department of Anesthesiology, Tacoma General Hospital and Pierce County Hospital, Tacoma, Washington. Consultant in Anesthesiology, St. Joseph Hospital, Northern Pacific Hospital, Mary Bridge Children's Hospital, Madigan Army Hospital, and Veterans Administration.

and conductive mechanisms. It is considered to be measurable and constant, although it can be modified by drugs and psychic factors and completely obviated by interruption of its pathways by chemical (nerve block) or surgical means. The reaction to pain, on the other hand, is a complex physiopsychologic process which involves the cognitive functions of the individual. It is a feeling state, or what Aristotle called "the passion of the soul," and represents the emotional and physiologic expressions resulting from the perception of pain. It is what the individual feels, thinks, and does about the pain he perceives. The pattern of reaction depends, in part, upon what sensation means to the individual in the light of his past life experience and his attitude toward it. The latter, in turn, depends upon the mood, emotional status, the will, the state of the various cerebral processes, the presence or absence of anxiety, and many other factors. In other words, the patient's complaints and his physical and mental responses to the perception of pain are the manifestations of his reaction. There is no constant, necessary, or proportionate relationship between the perception of pain and the reaction thereto. The obvious conclusion is that the "quale" or feeling state is a completely subjective phenomenon and is to the one that suffers the most relevant aspect of pain.[4] This is one of the most important and fundamental facts about pain which must be accepted with its full implications if one is to be successful in managing patients with intractable pain.

There are several other important characteristics of pain which must be kept in mind. The intensity of pain arising from a lesion is independent of the size of the lesion; and when two or more sources of pain stimuli exist coincidentally, perception of pain is monopolized by the most intense. Pain of long standing, no matter whether moderate or severe, produces physical and psychologic depletion that varies widely between individuals, which may give evidence of basic personality differences.[5] Patients with chronic pain have a gradual but complete alteration in their attitude to their environment. Consequently, they have no other interest; and the pain becomes in fact a consuming problem which completely dominates their lives. In such cases, interruption of pain pathways with consequent complete abolition of pain perception cannot be hoped to solve the problem entirely—in many instances the problem is much more complicated and necessitates a long-term application of psychotherapeutic and rehabilitative measures as well.

Role of the Anesthesiologist

The role of the anesthesiologist in the management of intractable pain may be in one of two categories: (1) providing special technical aid which may serve to promote the overall management by diagnostic or therapeutic procedures or (2) assuming the responsibility for the overall management of the patient. In most instances it will be in the first category, and the anesthesiologist will act as a consultant whose contribution will, of necessity, be an exercise rather than a discipline, since the procedures he can offer are inherently limited in their place among the many things which must be done for most patients with severe intractable pain.[5]

The anesthesiologist has certain attributes which make him fit as a valuable colleague who, under a suitable combination of circumstances, can contribute significantly to the problem.[2] He has, or should have, the skill and dexterity to interrupt sensory pathways; and although proficiency in this method for surgical anesthesia does not necessarily insure success when employed to control nonsurgical diseases, it is a great asset. In addition, his everyday experiences with depressant drugs, particularly the analgesics and sedatives, make him acutely aware of the advantages as well as the complications with the use of these medicinals. Finally, the anesthesiologist in his daily practice sees and cares for patients who are ill and fear pain. Consequently, he naturally develops a sympathetic understanding, a considerate feeling, and patience for those who suffer. This is without doubt the most important single qualifying attribute.

Requisites for Optimal Results

Regardless of the category in which he may find himself, the anesthesiologist can contribute significantly to this problem only if he observes certain important requisites.[2, 6, 7] Perhaps the first and one of the most important is that he must assume responsibilities and discharge obligations as a physician rather than act merely as a technician who is an expert in inserting needles. Even in the cases where he is acting as a consultant skilled with nerve blocks, it is important that the anesthesiologist have an in-

sight to the problem. His behavior toward the patient must be that of the doctor who is particularly interested in the patient's welfare. He must bring the patient a quiet and considerate humanity and a confidence and security based upon the conviction that he, the physician, will do all possible to help solve the problem. The anesthesiologist, as well as any other physician who is involved in any way in the management of pain, must make the patient feel that his unique individuality is recognized and his problem is not meaningful to him alone.

It is essential for the anesthesiologist to make, confirm or reject the diagnosis, even when he is acting in the capacity of a consultant. Even if the diagnosis is obvious, it is advisable to investigate the problem fully because in some cases additional information may be obtained that will aid him in performing his task better. To accomplish this, a detailed history and thorough physical examination are essential, together with knowledge of pain syndromes and the underlying mechanism. Taking the history will afford the physician the opportunity to become acquainted with the patient; to investigate his personality; and, most important, to establish rapport with him and win his confidence—factors which are so important in the management of any patient, but particularly in those with intractable pain.

At this juncture it is important to interject a few words regarding the responsibility of the anesthesiologist or any other consultant to the patient's physician. Since the success of the overall management of the patient with chronic pain in a large measure depends upon the development and maintenance of unswerving confidence in his personal physician, it is the duty of all consultants not to say or do anything which will cause deterioration of that confidence.

Once a diagnosis has been made, it is necessary to determine whether nerve blocking is indicated. It is important to employ this method in indicated cases only, for unless haphazard and careless selection of patients is avoided, the results will be poor and the method will come into disrepute. In fact, the anesthesiologist can do more harm than good if he assumes or even condones the deprecative attitude toward nerve blocks of "Let's try it out and see if it will work—we've got nothing to lose." If the blocks are not indicated there *is* a great deal to lose—the confidence of the referring physician and the patient, who might be left disillusioned, skeptical, and critical of further treatment to the point of being uncooperative.

If nerve blocks are indicated, it is necessary to decide what is to be accomplished with the procedure; that is, whether it is to be performed for diagnostic, prognostic, or therapeutic purposes.

Once it has been established that the block is indicated, it is necessary to inform the patient about the various phases of the nerve block management. The purpose of the block, the general outline of the procedure, the effects that may be expected, what may be accomplished, and what is being sought must be clearly explained to the patient. If it is explained beforehand that the initial block may not produce the desired effects and that several blocks may be necessary before the efficacy of the method can be determined, the patient is less likely to become discouraged before all the treatment has been completed. The necessity for his cooperation should be particularly emphasized, for an informed patient is likely to be a cooperative patient. Throughout his discussion, the anesthesiologist must demonstrate full confidence in this method of management, for unless the physician believes in the method himself, the results will be uniformly poor no matter how effectively the pain pathways are interrupted. On the other hand, one outstanding authority has found that more than 60% of all patients who are blocked for pain derive an appreciable degree of relief provided the operator is sincere in his attempt to give the patient relief.[5]

Experience with the block procedure to be employed and a familiarity with the drugs which are suitable and reliable for each particular case is another important requisite. Nerve blocks must be performed carefully and correctly with meticulous attention to anatomic detail and with utmost skill and gentleness. The practitioner should be fully acquainted with the structures that are traversed by the needle and the complications inherent in such procedures. It bears emphasis that haphazard introduction of a needle in the general area of a nerve in the hope that it will be anesthetized must be abandoned. Unpredictable variations in anatomy and tissue responses and the approach to nerves through the intact skin impose enough inaccuracy without introducing the

additional one of improper execution due to a lack of knowledge of technique. This is particularly important when the block procedure is done for diagnostic or prognostic purposes because in such instances much depends upon the results of the procedure. It is therefore essential to localize exactly and precisely the involved nerves and to employ small amounts of solution. Thus, while for therapeutic purposes in most instances a large amount of solution can be used without affecting the result of the block, such large amounts will spill over and affect other nerves and are, therefore, contraindicated in diagnostic or prognostic procedures.

During and following nerve blocks, it is essential to assess carefully the results as objectively as possible. Observation of the reaction of the patient to the formation of the intracutaneous wheal, to the insertion of the needle through pain-sensitive structures, and to paresthesia aids in evaluating the problem. Following the block, the completeness of the interruption of the nerve impulses should be ascertained. When the adequacy of the block procedure is established, the desired effects for relieving the pain must be carefully assessed. This may require observation of from a few hours to several days or weeks. The amount, type, and duration of relief obtained should be carefully noted and recorded.

It is important to realize that the nerve block method of managing intractable pain has certain limitations and is not completely innocuous. Chemical neuritis and neuropathy with paralysis can occur; and accidental pneumothorax, total spinal anesthesia, circulatory and respiratory collapse, and even death have been reported.[8] Unless the anesthesiologist is ready to admit that analgesic blocking has certain limitations, is replete with certain disadvantages, and is not infrequently attended by failure, the results will be disappointing to both patient and physician.

It is important for the anesthesiologist to realize that nerve blocks, in most instances, contribute only a small part to the total solution of the problem and are thus to be considered as an adjunct to other methods of therapy rather than the sole form of treatment. Frequently, intractable pain requires the joint effort of the patient's physician and a number of specialists. In passing, it might be mentioned that the formation of a true *Pain Clinic* and the active participation of the anesthesiologist in such a group is of great value in the management of this problem. Such a clinic, which should be under the direction of a highly trained individual particularly interested in, and thoroughly familiar with, all phases of pain and its management, should include a neurologist, a neurosurgeon, a psychiatrist, an internist, an orthopedist, a radiologist, and a physiatrist, in addition to the anesthesiologist. This group can review difficult diagnostic and/or therapeutic pain problems and thus act in a consulting capacity. Moreover, meetings of such a group afford an excellent opportunity to exchange ideas and knowledge about this difficult problem.

Technical Considerations

For obvious reasons, no attempt will be made to discuss techniques except to point out that any nerve capable of transmitting pain can be injected chemically to interrupt its conduction. Since experience can only be gained from performance, it is suggested that the physicians who assume the responsibility of executing these blocks for the management of nonsurgical pain become skillful and dexterous by first performing them repeatedly for surgical anesthesia.

Several adjuvant methods that are being presently employed to aid the execution of nerve blocks should be mentioned. The value of roentgenograms to assist in the proper placement of needles is generally acknowledged. They are particularly indicated in diagnostic and prognostic blocking and in some therapeutic blocks where small amounts of solutions are necessarily injected. Preliminary injections of contrast media with subsequent roentgenographic visualization prior to injecting the analgesic solution can be employed in an effort to determine the diffusion of the injected solution.[9] The use of hyaluronidase to enhance the spread of the solution and thus increase the success of complete blocks has little to recommend it except the inexperience of the operator. Moreover, it increases the incidence of toxic reaction,[10] probably by accelerating the absorption of the local anesthetic drugs.

As previously mentioned, the proper choice of solution for injection is a most important consideration. For diagnostic and prognostic blocks that are intended to be completely reversible and of short duration, aqueous solutions of the commonly employed local anes-

thetic agents are the most satisfactory. There does not seem to be any reliable evidence to indicate that any one local anesthetic agent has outstandingly superior qualities over the others. Although procaine hydrochloride for many years has been claimed to be the safest and most satisfactory drug, this has been the experience of those clinicians who have compared all drugs for a large number of cases under clinical conditions. In our clinic 1 or 2% solutions of Xylocaine or Cyclaine and 0.1 or 0.2% solutions of Pontocaine (Amethocaine) Hydrochloride or Nupercaine have been found satisfactory—the former two for their short latent period and the latter two for their longer lasting effects, which continue for as long as six to eight hours as compared with one to two hours for procaine.[11] We have observed less toxic reaction following the use of Pontocaine than following the administration of any drug which we have used.

For more prolonged blocking, various agents have been advocated. *Oil solutions* of local anesthetics, formerly recommended as a means of delaying the absorption of the analgesic agent and thus prolonging its action, have been found unsatisfactory because the blocks are frequently incomplete and unpredictable. Recently, a solution of procaine base and hydrochloride in polyethylene and propylene glycol, called "Efocaine," was introduced for the purpose of producing analgesic blocks of several days' duration. The preliminary reports[12] were encouraging, but recent reports indicate that it is not an innocuous drug. Postinjection neuritis and pain sometimes followed its use, and severe neurologic complications have been reported.[13] The use of *ammonium compounds* has been advocated by some authors,[14] who claim that such agents block only the unmyelinated fibers of somatic nerves, thus eliminating pain without interfering with other modalities of sensation. While a few patients have experienced prolonged relief from pain following the injection of such agents, most patients have not had such satisfactory results. The effects of these compounds cannot be predicted as to either completeness or duration. Since its use was suggested to me by Mandl,[15, 16] I have employed an aqueous solution of 6% *phenol* quite extensively to effect prolonged sympathetic interruption and have found this agent efficacious, as have a number of others.[17] In some patients sympathetic interruption for as long as 13 months has been noted, although in most instances the block lasts from two to six weeks only. It is not as effective on somatic nerves. Postinjection neuritis with neuralgia due to irritation of somatic nerves can occur with this agent. *Benzyl alcohol* in 0.75 to 2.0% concentration is a satisfactory agent for prolonged blocking; and although neuritis is occasionally seen subsequent to its use, it is mild and of short duration. Absolute *ethyl alcohol* remains one of the most effective drugs for prolonged interruption of nerve impulses.[18] Unfortunately, its use is followed by postinjection neuritis with neuralgia in over 25% of cases; but this usually is mild and lasts only a few weeks, although occasionally it is so severe as to overshadow the original complaint. This complication is particularly serious in patients with psychosomatic disorders. The use of this drug, therefore, should be reserved for the management of severe, intractable pain in patients unsuited for surgery or in those who refuse operation.

The Role of Nerve Blocks in Pain Control

The following brief discussion of painful conditions is included to indicate the use of nerve blocks in the management of intractable pain. It is based on my experience with this method during the past 12 years, during which period my associates and I administered over 6,500 analgesic injections to approximately 3,500 patients* for a great variety of conditions. A detailed analysis and account of these cases is included in our book, recently published,[2] wherein all painful syndromes amenable to nerve block are discussed; the book also includes a detailed bibliography following the discussion.

Neuralgias

Neuralgia is a broad descriptive term that is often misused. We employ it to denote pain of any type that has segmental or peripheral nerve distribution. It is usually the symptomatic expression of neuritis, which is the result of inflammatory, circulatory, toxic, degenerative, metabolic, or neoplastic disturbance in the nerves or sensory ganglia. It may be the first manifestation of radiculitis, meningitis, myelitis, neoplastic disease of the spinal cord or brain, or pathology of the vertebra, especially malignancy. Not infre-

* This total includes a large number of patients treated in Madigan Army Hospital, Tacoma.

quently it heralds an organic disease and may be for weeks, months, or years the only manifestation of the pathologic process. Sometimes it is the expression of some constitutional disturbance which for some unknown reason has a selective affinity for a specific nerve or nerves. Occasionally, the neuralgia constitutes the entire clinical syndrome without any apparent etiological basis or structural changes; or it may be the reflex manifestation of a disorder in a viscus removed from the site of pain. Rarely, neuralgia may be of purely psychogenic origin—mostly hysterical conversions and occasionally delusional projections. It is apparent, therefore, that in order to treat neuralgia properly, it is most important to ascertain the cause and, if possible, remove it.

Neuralgias of the Face, Head, and Neck— Neuralgia along the distribution of one of the cranial nerves or of the upper cervical nerves which supply the back of the head and neck is among the most common types of nerve pain. Such neuralgia should be distinguished from the so-called atypical neuralgia of the face which is a vascular disturbance. True neuralgias of the head and neck may be divided into primary and secondary types. The primary neuralgias have similar characteristics, including unknown etiology (so-called idiopathic neuralgia) and periodic pain which is lancinating and very brief. In these primary neuralgias, interruption of the pain pathways always produces relief. The secondary type of true neuralgias usually are manifestations of clinically apparent pathological processes such as tumors and inflammatory processes, and are characterized by constant aching or burning pain and sensory disturbances.

One of the most severe and painful conditions is *tic douloureux* of the trigeminal nerve, or the so-called major trigeminal neuralgia. This disease, the etiology of which is still unknown, is manifested by sudden, intense, stabbing, shooting pain in some portion of the face. The pain is usually brought on by a stimulation of a so-called trigger by drinking, talking, washing the face, or brushing the teeth. Analgesic blocks can be used to great advantage in the management of tic douloureux either as diagnostic, prognostic, or therapeutic procedures. All injections should be first done with local anesthetic solutions in order to confirm the diagnosis and to prognosticate the effects of more prolonged interruption. Following this, the nerve may be injected with alcohol to produce relief for several months. In most instances, one alcohol nerve block is sufficient; and when the pain returns, the patient should be advised to have a retrogasserian neurotomy, which produces a cure. Recently, decompression of the gasserian ganglion has been advocated as an alternative operative procedure.[19, 20] This has the advantage that it does not produce numbness of the face and other complications inherent to the surgical interruption of the trigeminal nerve. In very poor risk patients in whom major neurosurgical operations are contraindicated, repeated alcohol nerve block should be employed.

Glossopharyngeal neuralgia is not as common as trigeminal neuralgia, but we have seen 7 cases in our community. This condition is characterized by sudden, severe, lancinating pain in the throat with radiation to the angle of the jaw and occasionally to the ear and to the thyroid cartilage; it is brought on by swallowing, coughing, clearing of the throat, yawning, or sudden rotation of the head. Swallowing may be so distressing that the patient abstains from eating solid foods. As a consequence, many of the patients are frequently dehydrated, malnourished, and cachectic. Trigger areas often are found in the tonsils, pharynx, or back of the tongue. Diagnosis is confirmed by topical anesthesia of the throat, which should completely relieve the condition. In some atypical cases, however, the vagus nerve is also involved and it becomes necessary to do diagnostic-prognostic blocks at the base of the jugular foramen.[21] This procedure will completely relieve glossopharyngeal neuralgia which involves the vagus nerve, even in cases in which topical anesthesia of the throat is ineffective. Intracranial section of the glossopharyngeal nerve produces a cure.

Rarely, the same characteristic symptoms of atypical neuralgia involve the sensory portion of the facial nerve, known as the nervus intermedius; or they may involve the superior laryngeal branch of the vagus nerve. The management of these is similar to that described above.

Atypical facial neuralgia, formerly thought to represent neuritis of the sphenopalatine ganglion or of the vidian or petrosal nerve,[22] is now considered to be caused most frequently by distention of the internal maxil-

lary artery and its branches.[23] Management should include a thorough search for, and elimination of, any possible etiologic factor such as infectious process of the bones or soft tissues of the face, dental disorders, ocular pathology, or dysfunction of the temporomandibular joint. In these cases blocks are of little therapeutic value, but may aid in the differential diagnosis. Since in many instances the precipitating or aggravating factor of vascular distention is emotional stress, tension, or anxiety,[23] psychotherapy is of great value. Vasoconstrictors are effective to reduce the distention. Associated muscle spasm can be relieved with blocks and physical therapy.

Occipital neuralgia is usually a manifestation of intraspinal, vertebral, paravertebral, or soft tissue disorders involving the upper cervical nerves or spinal cord. Due to their peculiar anatomic position, the upper two cervical nerves are particularly susceptible to trauma, as occurs, for example, in "whiplash" injuries.[24] Proper management of any case of occipital neuralgia necessitates thorough search for, and eradication of, the cause. Nerve blocks may be used for diagnostic-prognostic purposes. In certain types of cases, repeated blocks produce prolonged and even permanent relief.

Neuralgia of the Trunk and Extremities— Segmental or peripheral neuralgia involving the cervical, thoracic, or lumbosacral nerves is usually the symptomatic expression of a mechanical or inflammatory radiculitis or mononeuritis. "Idiopathic" neuralgia is extremely rare, if it exists at all; and a thorough preliminary examination should be made where the latter condition exists in order to exclude the possibility of spinal cord tumors, herniated discs, and other organic lesions that can be eliminated surgically. In most cases of segmental peripheral neuralgia, nerve blocks are only of value as diagnostic or prognostic procedures. Of course, if the cause cannot be eliminated, repeated injections or, better still, continuous segmental blocks can be used to great advantage to produce symptomatic relief.

Cervicobrachial neuralgia is usually due to osteoarthritis; herniated cervical disc; root sleeve fibrosis; or pressure in the brachial plexus by a spastic and/or hypertrophied scalenus muscle, an abnormal rib, or a small costoclavicular opening. In such cases blocks are only of diagnostic or prognostic value, or of value as a temporary measure to alleviate extremely severe pain. In patients with a scalenus anticus syndrome, repeated injections of the muscle may produce prolonged relief and should always be tried before surgery is done. Repeated blocks may also be tried in patients with osteoarthritis. In these cases, temporary relief of pain and muscle spasm may be effective in interrupting a vicious circle of pain-spasm-pain and thus effect prolonged and much-needed relief.

Thoracic neuralgia may be due to an orthopedic disorder of the spine, may be a symptom of post-traumatic or postinfectious neuritis, or occasionally may be caused by pressure from a tumor. Obviously, in order that it may be treated properly, the cause should be ascertained and an attempt made to eradicate it. Musculoskeletal causes are best eliminated by orthopedic measures, although in some cases paravertebral blocks are valuable adjuncts. Such blocks are also of great therapeutic value for post-traumatic or postinfectious neuritis; the repeated or continuous blocks can effect an amelioration of symptoms, curtailment of the course of the disease, and prevention of complications. Herpes zoster is a good example of a disease in which such blocks can be used; they not only relieve the pain, but also shorten the course of the disease and decrease the incidence of postherpetic neuralgia. The latter is a very difficult problem which frequently cannot be solved even by severing the pain pathways. Blocks should be tried before surgical section is done to predict its effects. Occasionally, they produce prolonged relief.

It is now generally agreed that *lumbosacral segmental pain* is most frequently produced by herniated discs. In these patients, nerve blocks can be used for differential diagnosis; and if the pain and muscle spasm are extreme, blocks are effective to temporarily relieve them while more definitive therapy is instituted. Continuous peridural block for several days is an excellent adjunct in such cases.

In patients with neuralgia who are relieved with temporary block and in whom the cause cannot be eliminated, prolonged interruption of the pain pathways may be necessary. In patients who are extremely poor risks, alcohol injected in the subarachnoid area may be employed to afford prolonged relief of pain.

Causalgia and Other Reflex Sympathetic Dystrophies

Major causalgia is a condition that is due to incomplete severance of a major peripheral nerve such as the median or sciatic, and is characterized by severe burning pain, hyperalgesia, and vasomotor and sudomotor disturbances. This condition is very seldom seen in civilian practice, but it is one of the most difficult problems that confronts the military surgeon during wartime. Sympathetic blocks almost always produce relief and should always be done as a diagnostic and prognostic procedure.[25] Moreover, if this procedure is done soon after the onset of the pain and repeated frequently, it may effect prolonged and even lasting relief. If it does not, sympathectomy will.[25, 26]

Minor causalgias, post-traumatic pain syndromes, post-traumatic osteoporosis, shoulder-hand syndrome, and other reflex sympathetic dystrophies are frequent and serious problems that confront all physicians, but particularly those who practice industrial medicine. These conditions are very important because they present confusing symptoms and often remain undiagnosed for a long period of time. It is generally agreed that, like major causalgias, these conditions involve the sympathetic nervous system; and blocking the sympathetic ganglia that supply the affected part will temporarily improve the condition. In some cases a series of blocks will effect permanent relief, particularly if done early.

Phantom limb pain is often a difficult entity. It is considered by some[26,27] as a form of reflex sympathetic dystrophy, while others[28] believe it is a psychosomatic problem. In most cases nerve blocks are of great value as diagnostic and prognostic procedures. No neurosurgical operations to interrupt pain pathways should be attempted without prior use of blocks. In patients with predominantly burning pain, sympathetic blocks may effect prolonged relief.[2, 27]

Pain Consequent to Peripheral Vascular Disease

The pain that is present in such peripheral vascular diseases as Raynaud's disease or phenomenon, traumatic vasospasm and other vasospastic conditions, or thromboangiitis obliterans and arteriosclerosis can be temporarily relieved with sympathetic nerve blocks. The pain and edema of thrombophlebitis due to the existing reflex vasospasm can be ameliorated with repeated or continuous sympathetic blocks. This procedure greatly diminishes the morbidity and affords relief, which is appreciated by the patient, and, in addition, will prevent the occurrence of postphlebitic edema. The same gratifying results can be obtained in frostbite and acute arterial catastrophies. We have used sympathetic blocks to treat a large group of patients with frostbite sustained in Korea and have observed good results.[2]

In most instances of Raynaud's disease, thrombo-angiitis obliterans, and arteriosclerosis, blocks are used solely to prognosticate the effects of sympathectomy, although the value of such procedures in the organic disorders has been questioned. In some poor risk patients prolonged blocks produced with phenol or alcohol can be used to effect relief and vasodilatation with consequent improvement of tissue nutrition.

Visceral Pain

Diagnostic and therapeutic nerve blocks may be valuable for patients with visceral pain. The pain of pulmonary embolism can be dramatically relieved with stellate ganglion blocks. Discomfort due to asthma may also be alleviated with the same procedure in a few selected patients, although in general the procedure is of no value. Cervicothoracic blocks can be used in managing severe, intractable angina pectoris or aortic aneurysm. The pain of pleurisy can be relieved with intercostal nerve blocks. The severe, excruciating, and intractable pain of acute pancreatitis can be relieved by continuous segmental peridural block, or blocking of the celiac plexus or the paravertebral sympathetic ganglia. These procedures, in addition to relieving pain, improve the patient's condition by releasing the visceral vasospasm. The severe pain of gallbladder colic, renal colic, and other visceral pain can be temporarily relieved by similar procedures.

Musculoskeletal Pain

The pain of such conditions as ankle and other joint sprains, fractured ribs, fractured vertebrae, painful hip, acute torticollis, low back pain, painful shoulder, bursitis, tendinitis, periarthritis, and acute myalgia can be permanently relieved by repeated blocks using solutions of local anesthetics. This method of therapy affords sufficient pain relief to allow active mobilization and the use

of physiotherapeutic measures and thus enhances a rapid improvement.

In acute myofacial disorders with trigger areas, injection of a small amount of a local anesthetic solution often produces dramatic relief of pain and aborts what is usually a long-lasting disability. In order to obviate the disadvantages of narcotics in postoperative pain, repeated intercostal blocks or, better still, continuous segmental peridural blocks may be done with solutions of longer acting agents such as Pontocaine or Nupercaine and may thereby prevent postoperative pulmonary complications.

Pain of Inoperable or Recurrent Cancer

The excruciating pain that is sometimes present in inoperable or recurrent cancer may be adequately relieved with nerve blocks. While this method has certain limitations and cannot be considered as the only form of definitive therapy for these painful states, it does offer certain advantages that may not be had with some other forms of management. Properly executed nerve blocks can effect complete relief of pain and enable the sufferer to tolerate more intensive x-ray and radium therapy and other forms of medical treatment that would not ordinarily be tolerated. In addition, blocks are not accompanied by the disturbance of functions of the gastrointestinal, circulatory, and central nervous systems that often accompanies progressively larger doses of narcotic drugs, nor do they impose the risk of major surgical procedures that are usually not tolerated by poor risk patients. Most clinicians who have had much experience in coping with this problem are of the opinion that in the majority of *poor risk* patients with intractable pain from inoperable malignant lesions, alcohol nerve blocking is the method of choice. In a group of 137 patients with severe intractable pain associated with neoplastic diseases treated with prolonged nerve blocks, 64% obtained complete relief until they died, 23% obtained moderate relief, and 13% obtained only minimal or no relief.[29] This compares favorably with results in neurosurgical operations.[30]

Summary

Attention is again called to the fact that the management of intractable pain is a difficult clinical problem that should interest every practitioner and that frequently requires the joint effort of several physicians in various fields. The anesthesiologist or any other physician who is proficient in executing analgesic blocks can play a significant role in the management of patients with intractable pain, provided he observes certain requisites. A correct diagnosis, an understanding of pain mechanisms, an adequate knowledge of the anatomy and neurophysiology of pain, a thorough knowledge of the techniques and the agents best suited for various analgesic blocks, and an objective assessment of results are important requisites without which optimal results cannot be realized. Mention is made of various pain syndromes to indicate the value of analgesic blocks in their management.

Tacoma General Hospital.

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INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION
INTERNATIONAL SCIENTIFIC ASSEMBLY

MILWAUKEE AUDITORIUM — NOVEMBER 14–17

MONDAY, NOVEMBER 14

J. S. Hirschboeck, M. D., Milwaukee: Newer Treatments for Pernicious Anemia
P. C. Bucy, M. D., Chicago: Clinical Discussions of Neurology and Neurological Surgery
J. E. Affeldt, M. D., Los Angeles: Mechanical Treatment of Pulmonary Failure
C. L. Randall, M. D., Buffalo, N. Y.: Clinical Considerations of Ovarian Cystomas
W. G. Sauer, M. D., Rochester, Minn.: Regional Enteritis — Diagnosis and Medical Management
W. H. Cole, M. D., Chicago: Strictures of the Common Duct
L. L. Lovshin, M. D., Cleveland: Helpful Signs in the Recognition of Functional Disease
H. M. Carryer, M. D., Rochester, Minn.: The Care of the Seriously Ill Asthmatic Patient
J. A. Schindler, M. D., Monroe: A New Method of Treating Emotionally Induced Illness Adaptable to General Practice
W. P. Blount, M. D., Milwaukee: Fractures in Children
J. E. Kirk, M. D., St. Louis, Mo.: Hypogonadism in Middle-aged and Elderly Men
F. G. Ebaugh, M. D., Denver: The Use and Abuse of Sedative Drugs

TUESDAY, NOVEMBER 15

F. D. Murphy, M. D., Milwaukee: Evaluation of the Methods of Treatment of Essential Hypertension
Charles Ragan, M. D., New York: The Management of Rheumatoid Arthritis
H. H. Reese, M. D., Madison: Present Day Concepts of Muscular Dystrophy and Atrophy
W. B. Slaughter, M. D., Chicago: Newer Concepts in the Treatment of Cleft Palate and Hare Lip
R. B. Cattell, M. D., Boston: Carcinoma of Thyroid
T. C. Chisholm, M. D., Minneapolis: Tumors in Infancy and Childhood
I. F. Duff, M. D., Ann Arbor, Mich.: Intra-articular Steroids: Clinical Applications and Laboratory Effects
R. A. Reis, M. D., Chicago: Operative Treatment of Uterine Prolapse
Leon Schiff, M. D., Cincinnati: Jaundice
R. J. Noer, M. D., Louisville, Ky.: Intestinal Obstruction

WEDNESDAY, NOVEMBER 16

W. M. Allen, M. D., St. Louis, Mo.: Endocrine Therapy in Gynecology
Carlo Scuderi, M. D., Chicago: Both-Bone Fractures of the Leg
S. A. M. Johnson, M. D., Madison: The Papulosquamous Skin Conditions, Their Diagnosis and Treatment
C. P. Bailey, M. D., Philadelphia: Recent Significant Developments in Intracardiac Surgery
W. A. Altemeier, M. D., Cincinnati: A Current Evaluation of the Antibiotics in Surgery
E. H. Botterell, M. D., Toronto, Canada: Fracture Dislocations of the Thoracolumbar Spine with Spinal Cord Injury
J. C. Locke, M. D., Montreal, Canada: Retrolental Fibroplasia
Alton Ochsner, M. D., New Orleans: Surgery of Diseases of the Lung
F. J. Hofmeister, M. D., Milwaukee: Problems of Ovarian Tumors
J. Z. Bowers, M. D., Madison: The Use of Radioactive Iodine in the Treatment of Thyroid Disease

THURSDAY, NOVEMBER 17

M. M. Cummings, M. D., Washington, D. C.: Newer Concepts of the Epidemiology of Sarcoidosis
Virginia Apgar, M. D., New York: Fetal Resuscitation and Respiration
Waltman Walters, M. D., Rochester, Minn.: Surgical Lesions of the Adrenal Gland
J. A. Evans, M. D., Boston: Malignant Hypertension
George Crile, Jr., M. D., Cleveland: The Present Status of Surgery in the Treatment of Cancer
M. H. Siefert, M. D., Chicago: The Treatment of Bulbar Poliomyelitis
J. J. Procknow, M. D., Chicago: The Diagnostic Problem of Histoplasmosis
C. L. Kiehn, M. D., Cleveland: The Late Treatment of Burns
T. J. Greenwalt, M. D., Milwaukee: Why Not 'Cosmetic' Transfusions?
H. M. Morfit, M. D., Denver: Cancer of the Mouth and Neck

The Choice of Hypertensive Patients for Splanchnicectomy*

By JAMES A. EVANS, M. D.
Boston, Mass.

SINCE the advent of Apresoline, the ganglionic blockers (hexamethonium, Ansolysen), and rauwolfia, the recourse to splanchnicectomy for the relief of hypertension has dwindled greatly. We performed 49 such operations in 1951, 23 in 1952, 26 in 1953, and only 8 in 1954. In the 1940's we performed as many as 80 to 90 a year. It is my conviction, however, that the pendulum has swung too far. Two reasons for this occurring are: the sales resistance on the part of the patient with the operation's known morbidity, and the lack of courage in our own convictions concerning what splanchnicectomy in the long run can accomplish for the severe hypertensive patient.

Since most Grade I hypertensive patients have a good prognosis anyway, we reject them for operation and prefer simple rauwolfia therapy, especially if their hypertension is of the neurogenic type, because we believe they will live as long without operation as with it. This probably will prove to be all the more true in even more cases with the modern hypotensive drugs.

In patients with Grade II eyegrounds, sclerosis of the arterioles, and compression at the arteriovenous crossings, we used to advise operation if the patients had signs of degenerative cardiovascular or renal disease not too far advanced. To be specific, we operated if they had enlarged hearts, episodes of nocturnal dyspnea, or left ventricular failure. We rejected those who had complete congestive failure or had had myocardial infarction, because of the operative mortality and the poor results in those patients who did survive. In patients who had severe angina without severe myocardial infarction, however, we did a very extensive sympathectomy from the first thoracic vertebra to the second lumbar vertebra, thus including the anginal pathway for pain, with complete or substantial relief of angina in 90 per cent of the patients. Now we may try drug therapy first if the patient insists. But the "on again, off again" effect of the ganglionic blockers may further endanger the coronary flow. Indeed, after splanchnicectomy, one of our patients had angina only when experiencing postural hypotension.

In instances of cerebrovascular disorder, we did splanchnicectomies if the patients had had light strokes with evanescent symptoms of cerebral encephalopathy. But if they had evidence of widespread and permanent infarction of the brain with permanent residual of hemiplegia, they were rejected for operation.

If patients with Grade II fundi had minor evidence of renal impairment but still had good concentration of the dye on the intravenous pyelogram, and the nonprotein nitrogen was normal, they were advised to have the operation even if the phenolsulfonphthalein concentration test and urea clearance test results were below normal. Sometimes under medical treatment the azotemia could be corrected and we would operate.

In all these categories of Grade II hypertensive patients we had to have at least the criteria of fair renal function with good concentration of the dye and no permanent azotemia.

Results seemed to justify this choice of patients because in follow-up studies of from six months to three years in such a group of Grade II hypertensive patients, we found that good results were obtained in 77 per cent of the cases.

If the results of drug therapy are unsatisfactory or if the patients become irked by the endless routine of taking pills, the frequent follow-up visits, the necessity of keeping their own blood pressure charts at home, or the expense involved, these same criteria as to renal and cardiac function should still apply in advising operation.

Now we come to the patient with hemorrhagic fundi, the so-called Grade III or IV hypertensive. He is called Grade IV if, in addition to hemorrhage and exudate, he has choked disks. The patient who has Grade

* Presented at the One Hundred and Fourteenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, May 4, 1955.

IV hypertension also often has renal necrotizing arteriolitis, which so greatly increases the mortality rate in this group. According to Keith, Wagener, and Barker two-thirds of Group III are dead in four years; and in Group IV, 9 out of 10 are dead in three years when treated by formerly used medical methods. Results of a recently completed review of our operated cases of malignant hypertension show that, at ten years, 46 per cent of the patients with Grade III hypertension are still living, whereas none is expected to be surviving at seven and one-half years. Of the Grade IV patients who had splanchnicectomies, one-third are still living at ten years, although only 5.6 per cent are expected to be surviving at six and one-half years. Surely such a method for saving lives of patients who have such a fatal disease as malignant hypertension should not be disregarded entirely.

The modern drugs are also highly successful in this field. They have the advantage that they can be tried in a group of patients with poor hearts and poor kidney function, on whom we would not want to operate. However, such drugs, too, are generally unsuccessful when kidney function is poor.

But consider the young, recently vigorous patient under 40. He may survive many years with proper treatment, either medical or surgical; and so, if we can save him at all, we prefer to offer him operation if his kidney and cardiac function warrant surgery.

If a patient who has either Grade II or the malignant variety of hypertension with hemorrhagic fundi has had episodes of cardiac failure and we can restore compensation, one adrenal gland is removed at the second-stage operation. We always make sure he has a normal adrenal on the first operated side because occasionally a patient has only one adrenal. Removal of one adrenal is not expected to alter his physiology in any way; but if splanchnicectomy does not prove adequate to control the disease, a total adrenalectomy can be completed a few months later with a minimum of operative procedure.

Some of these patients need every method in our armamentarium—low (200 mg.) sodium diet; the addition of the drugs after splanchnicectomy; and, ultimately, even total adrenalectomy.

In summary, the patients for whom splanchnicectomy is now recommended include:

1. The young person with malignant hypertension who still has fair kidney function.
2. The patient under 50 who has an enlarged heart or episodes of left ventricular failure, with good renal function, and who tires of the medical regimen or in whom the medical regimen is unsuccessful.
3. The patient with fugitive cerebrovascular episodes who fails to respond to, or tires of, the medical regimen.
4. The patient who might have intractable headache in spite of modern medical regimen.
5. The patient whose angina does not subside under a medical regimen but who has not had a myocardial infarction recently.
6. The patient with congestive heart failure and hypertension to whom, in desperation, we may now offer splanchnicectomy plus total adrenalectomy when it is thought that a trial of medical therapy would take too long to save him.

In all these categories renal function must be good enough to show adequate concentration of the dye on the intravenous pyelogram, and no azotemia should be present. Those patients who still concentrate urine over 1.020 sp. g. have the best prognosis after splanchnicectomy.

Lahey Clinic.

POSTGRADUATE PROGRAM ON PHYSICAL DIAGNOSIS AT MARQUETTE UNIVERSITY

A postgraduate course on physical diagnosis is being offered by Marquette University on six Wednesdays, December 7 through January 18, from 10 to 12 a.m.

The first three sessions—Cardiology I, Cardiology II, and Abdomen—will be held at Milwaukee County General Hospital on December 7, 14, and 21, respectively. The last three—Musculoskeletal Diseases, Chest, and Neurology—will be given at VA Hospital, Wood, on January 4, 11, and 18, 1956, respectively.

Dr. Joseph W. Rastetter, Associate Professor of Medicine and Assistant Director of the Department of Medicine at Marquette, will be the director of the course. Registration is limited to 30 persons. The Wisconsin Academy of General Practice is allotting 12 credits.

New Hope for Controlling Retrolental Fibroplasia

As It Looks to Your State Board of Health

FOR the past few years a condition recognized as retrolental fibroplasia has darkened our horizons as the leading cause of infant blindness. Today, because of medical and hospital research, we have new hope.

Study of the problem revealed that retrolental fibroplasia was almost entirely limited to the smaller or immature infant. Consequently, all steps in the care of these babies were explored. The conclusions reached point the way to a fairly simple solution—*controlled use of oxygen in the care of immature babies.*

Oxygen is still vital for many of these babies who have an underdeveloped respiratory system, high metabolic needs, and a tremendous adjustment to make to their new environment. Some, however, can get along without oxygen. Because of the part it plays in infant blindness, oxygen should be administered as any dangerous drug—on an individual basis and only on the physician's written order. The concentration of oxygen should always be kept under 40 per cent and should be reduced gradually, and as soon as possible. The condition of the baby should be reappraised daily, or preferably twice a day.

It is important that every doctor and nurse caring for the immature infant understand the need for controlling oxygen. With this in mind, the Maternal and Child Welfare Division of the State Medical Society has prepared the card preceding this page for distribution to the doctors and hospitals of Wisconsin. The card emphasizes that many children can be saved from the handicap of blindness and summarizes the precautions needed to control retrolental fibroplasia.

We seem to be receding from our peak of premature deliveries—6.7 per cent of all live births. The 1954 figures show 5.9 per cent—or 5,419—of all Wisconsin babies born before term. Although statistical studies for 1954 are not yet complete, it is probable that about 14 per cent of these babies—more than 750—fall in the weight group under 3 pounds 5 ounces, where retrolental fibroplasia is most likely to occur. As we acquire better understanding of premature care, more of these babies survive each month. It is important to assure them the best chance for normal vision. Examination of their eyes should be a routine for several months.

Although reporting of all blindness in young children may be incomplete, the roster of the Bureau for Handicapped Children now shows 83 under seven years of age who are blind, as compared to 17 in the same age group in 1941. Retrolental fibroplasia and German measles in the mother are indicated by physicians as the primary causes. Though we do not have the exact incidence, figures recently released by the National Society for the Prevention of Blindness indicate that from birth through six years, 48 per cent of blindness can be ascribed to retrolental fibroplasia.

The doctor can perform a real service by promptly referring blind or partially blind children to the Bureau for Handicapped Children, State Capitol, and to the public health nurse. Help is often needed in understanding, training, and guiding these children. Parents of two to six-year-old visually handicapped children may enroll for training institutes held annually at the School for the Blind at Janesville and in Milwaukee. Understanding the special needs of blind children can reduce emotional stress in the home and permit optimal development for the handicapped child.—AMY LOUISE HUNTER, M. D., *Director, Bureau of Maternal and Child Health.*

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A

ɔu probably know every answer!)

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Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: Lester E. McGary, M. D.

REPORT OF A CASE*

History: A 65-year-old white female complaining of "painful boils and running sores all over her body for five months" was admitted to the hospital on Feb. 25, 1955.

She had been well until October, 1954, at which time erythematous macules had developed at multiple sites on the trunk and extremities. These lesions had developed into painful papules and nodules from 2 to 6 cm. in diameter. Some had become indurated, deep ulcerated "running sores" which discharged a yellow pus for two or three months before healing. Several lesions had been incised and drained by the patient's local physician under the impression that they were part of a generalized furunculosis. The incised lesions had continued to drain for several weeks. Moderate fever had been present since the onset of the skin lesions.

A painful, tender, 3 by 4 cm. mass underlying an erythematous skin area had been present in the left breast for three or four years. The patient had had partial deafness, with bilateral 50% hearing loss, for several years. Her tonsils had always been sore. She had weighed 270 pounds for many years until her present illness, following which there had been a 10 to 20-pound weight loss. For several years she had had arthritis, with pain, swelling, and limitation of motion in both hands and wrists. She had a large abdominal incisional hernia which also had been present for a number of years.

Physicial Examination: The patient was a 250-pound, 4′10″ woman who was senile and hard of hearing. There was a huge abdominal incisional hernia projecting through a cholecystectomy scar. The hernial defect measured approximately 1 by 2 feet, and the abdominal contents projected through it to the level of the knees.

Multiple hard subcutaneous nodules of various sizes from 1 by 2 cm. to 3 by 4 cm. were located over the trunk and extremities. Some of these nodules were deep within the subcutaneous fat; others were superficial and raised the epidermis into an area of erythema. Most of them were painful. None were draining at the time of the examination. There was a hard, painful, 3 by 4 cm. nodule in the left upper breast. The patient's hands had fusiform swellings and stiffness of the proximal interphalangeal joints. The heart exhibited a normal sinus rhythm and good quality of tones. The patient had a grade II blowing apical systolic murmur.

Laboratory Studies: At the time of the patient's admission to the hospital, laboratory studies showed a hemoglobin of 15.8 Gm., a hematocrit of 45%, and a white blood cell count of 11,550. The differential was neutrophils 65%, basophils 1%, eosinophils 1%, lymphocytes 27%, mononuclear cells 6%. The nonprotein nitrogen was 36.5 mg./100 cc. The blood sugar was 110 mg./100 cc., and the sedimentation rate was 45 mm. in one hour. The albumin was 4.8 mg./100 cc., while the globulin was 1.9 mg./100 cc. The Wassermann was negative, and the C-reactive protein was 1+. Cholesterol was 235 mg./100 cc., and the complement fixation test for blastomycosis was negative. The urine had a specific gravity of 1.019 and a slight trace of albumin, the sugar determination was negative, and there was an occasional pus cell found on microscopic examination.

Course: On the fourth hospital day, subcutaneous nodules on the left and right arms and the breast were excised and sent for pathological examination. The patient's temperature had spiked to 102 degrees on the second hospital day, and postoperatively this febrile course continued with temperatures of 102 to 103.2 degrees. On the seventh hospital day, the patient was started on stilbamidine. Two days later the less toxic hydroxystilbamidine became available, and a 15-day course of 225 mg. every other day in 200 cc. normal saline was given intravenously. In spite of treatment, the febrile course continued. On the thirty-fifth hospital day, a morbilliform rash developed on the trunk, probably from the hydroxystil-

* From Madison General Hospital.

bamidine. The rash cleared during the next few days with administration of antihistaminics. On the forty-seventh hospital day, a second course of hydroxystilbamidine, plus iodides, was started. Two days later, what appeared to be a CVA or a cerebral infection developed. A spinal tap revealed a white blood cell count of 94; 62% of these cells were polymorphonuclear neutrophils. The spinal fluid protein was 120 mg./100 cc. Spinal sugar measured 23 mg./100 cc., and chlorides were 137 mEq. Spinal fluid cultures were negative for bacteria and fungi. Ptosis of the right eyelid, slurring of speech, and poor response to questions were noted. Several days later the patient began coughing bloody sputum. Heart sounds became distant. On the fifty-sixth hospital day, she expired.

Clinical Discussion

Dr. R. M. Becker: This is a case of a 65-year-old, white, farmer woman who had had a primary lesion in the left breast for three or four years with cutaneous extension to other areas of the skin that appeared five months before admission. During her hospital stay of about two months the disease process extended to the lungs, central nervous system, and the brain.

A differential diagnosis would include tuberculosis, carcinomatosis (breast), lues, mycotic infection (histoplasmosis, actinomycosis, blastomycosis, torulosis, coccidioidomycosis, moniliasis, or sporotrichosis), or panniculitis (Weber-Christian disease). A biopsy of the lesions, as was done, is absolutely essential to the diagnosis. Any of the preceding diseases mentioned could account for this patient's clinical picture, and histological and culture methods would be needed for diagnosis. Although tuberculosis, carcinomatosis, and lues could produce the picture, the rarity of such a clinical picture being presented by any of these three would militate against such diagnoses. Areas of panniculitis in an obese woman would account for the skin lesions described, and it is possible that this type of hypersensitive vascular reaction could develop into a full-blown lupus-like picture with involvement of the central nervous system and the lungs. However, this, again, is highly unlikely; and one would expect a higher sedimentation rate, a more positive C-reactive protein, and elevated globulin in the A/G ratio. Fungus or mycotic diseases could produce the picture and be the etiologic agent. To me, the clinical picture seems best to fit that of blastomycosis, despite the negative complement fixation test. In histoplasmosis, involvement of the reticuloendothelial system and pulmonary system usually overshadows the cutaneous manifestations. In actinomycosis, one would expect more pleural and abdominal sinus tracts and possibly less dermal involvement.

The patient presents an excellent story of cutaneous blastomycosis going into the systemic phase. Wisconsin being primarily a rural state, blastomycosis becomes an important disease because of its prevalence on farms, and primarily in males, in whom there is an eight times higher incidence of the disease. The organism, *Blastomyces dermatitidis*, is found in damp, wooden structures like woodsheds, silos, barns, etc. The portal of entry in most cases is the lung and respiratory tract. In a few cases the organism enters the skin through an area of abrasion. Schoenbach reported in a study of 243 cases that blastomycosis appeared more prevalent between the third and fifth decades, that 50% of those affected had initial respiratory symptoms, 4% of the cases followed injury to skin, superficial skin lesions were noted in 19%, and in 23% a subcutaneous nodular abscess was present. He describes the general gross mortality of the cutaneous going into the systemic phase as between 78 and 92%. Blastomycosis becomes an important disease when one realizes that while it is still in the cutaneous phase therapy is practically 100% effective, whereas in the systemic phase the mortality is usually very high, despite some encouraging reports following the use of stilbamidine or 2 hydroxystilbamidine. Many of these cases are treated as a generalized furunculosis until it becomes obvious that therapy with ordinary antibiotics is ineffective. Generalized furunculosis in a rural adult should make one suspicious of cutaneous fungus infection. Accurate diagnoses can be established by biopsies of the skin lesions and culture of the tissues removed. The complement fixation test and intradermal skin test in blastomycosis are of supplemental help; both may be negative in the presence of blastomycosis. False positives may be obtained in the presence of histoplasmosis, as there is some cross antigenicity between the blastomycetes and *Histoplasma* organisms.

Fig. 1.—Blastomycosis dermatitidis of the hand. Lesion is nodular with unbroken skin.

Treatment of blastomycosis depends on whether it is cutaneous or systemic. The cutaneous form is known to respond very adequately to a saturated solution of potassium iodide, 5 Gm. t.i.d., or about 10 to 20 drops t.i.d. Potassium iodide may actually cause a flare-up in cutaneous blastomycosis in an individual highly sensitive to blastomycosis antigens, and it is suggested that all patients with cutaneous or systemic blastomycosis be skin tested. If a strong positive skin test is obtained, several injections of the heat-killed vaccine should be given to produce a state of hyposensitization before starting iodide therapy. Among several drugs reportedly not effective in cutaneous or systemic blastomycosis are BAL, nitrogen mustard, cortisone, antihistamines, Chloromycetin, stilbestrol, penicillin, undecylenic acid, Promin, streptomycin, and Terramycin.

In systemic blastomycosis, Snapper has reported definite therapeutic benefit clinically with stilbamidine. This drug has been shown to inhibit the growth of *B. dermatitidis in vitro* and protects mice infected *in vivo*. It is an unstable organic water-soluble compound. In the presence of sunlight or ultraviolet light, it is quickly broken down to more toxic products and should be given intravenously from a brown bottle wrapped in dark paper. Patients who have received stilbamidine should be kept out of sunlight for a period of two to three months as it remains in the tissues from two to four months. Toxic reactions described are a toxic neuritis of the trigeminal nerve occurring one to two months after cessation of therapy. Venous thrombosis, as well as circulatory collapse, may occur if the drug is given too rapidly and may result in dermatitis medicamentosa as seen in our case today. A course of treatment consists of the daily administration of 150 mg. of the drug in 500 cc. of 5% glucose in water given intravenously for a period of 30 days.

2 hydroxystilbamidine has been described as being less toxic than stilbamidine. It seems to be more potent *in vitro*. Sutleth has noted no definite superiority in the effectiveness of hydroxystilbamidine over stilbamidine, but the toxicity described is considerably less. Hydroxystilbamidine may be given intravenously in larger amounts of 225 mg. daily for 30 days, but the same precautions concerning sunlight must be observed.

The terminal episode, which brought about this patient's demise, is a little more difficult to determine. With gross evidence of cerebral involvement one is tempted to feel that the patient had a cerebral hemorrhage, but the demise was much too sudden. Patients with cerebral hemorrhage will usually live for several hours. It is possible that the patient had a pulmonary hemorrhage, massive in character, into the intrathoracic space. The possibility of a rupture of an aortic mycotic aneurysm must also be considered.

Moderator—Dr. L. R. Prouty: It is obvious that this case from the very beginning was one of systemic blastomycosis with deep subcutaneous and cutaneous lesions rather than cutaneous blastomycosis with later systemic spread. In cutaneous blastomycosis, most of the lesions are found on the face, neck, or extremities. They begin as small, red papules or pustules which enlarge. The crusts assume a verrucous character. Small epidermal abscesses may radiate out from the edges of the lesions and often become necrotic ulcers with raised borders. The lesions remain confined to the skin and do not endanger the general health of the patient. There is little systemic reaction, and local lesions cause minimal pain.

This patient had not only multiple, deep, painful subcutaneous nodules; but there were no lesions on the face or neck and few on the extremities. There was considerable systemic reaction. A bone survey revealed no lesions, but the chest x-ray showed marked accentuation of bronchovascular markings and areas of patchy infiltration. These findings, together with hemoptysis, strongly sug-

gested pulmonary involvement with the same organism as that affecting the skin. This was further confirmed by fever, night sweats, loss of weight, cough, and increased sedimentation rate.

Had it not been for prompt reporting of typical *B. dermatitidis* organisms in the skin biopsy early in the patient's hospital course, the skin lesions might have been diagnosed as furunculosis, Dercum's disease, or other diseases mentioned by Doctor Becker. The pulmonary lesions could easily have been mistaken for tuberculosis, pneumonia, or bronchogenic carcinoma.

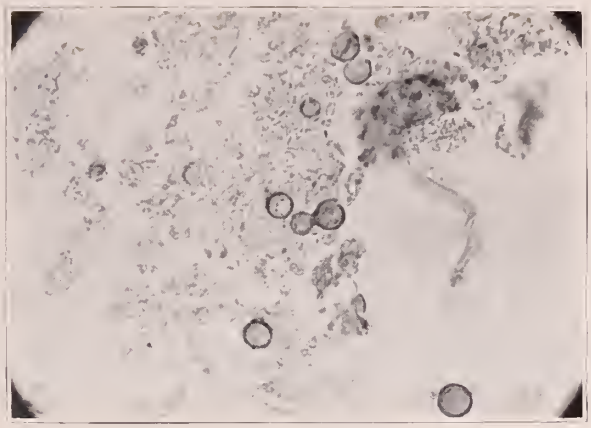

Fig. 2.—Blastomycosis dermatitidis cutaneous lesion. The spherical and budding form of the organism is readily seen with Gridley stain for fungi. (X 970)

Necropsy Findings

Dr. P. G. Piper: Doctor Becker presented the correct diagnosis in this case, and we agree that this case represents a systemic blastomycosis with cutaneous manifestations. The cutaneous lesions are of a papulopustular type with ulcerations. These lesions show ulceration of subcutaneous abscesses. There was no permission for post-mortem in this case.

Biopsies in the areas of abscess formation and ulceration reveal in the subcutaneous tissue a chronic inflammatory process with focal areas of necrosis. Single and budding spherical forms of the blastomycetes are found in these areas. There is hypertrophy and hyperplasia of the overlying dermis, which is common in blastomycosis. Foreign body giant cells, foci of acute and chronic inflammation, and fibrosis are observed.

The systemic manifestations can follow lung infection and subcutaneous abscess formation, ulceration of the skin, and often times congestive heart failure as a result of adhesions and pus within the pericardial sac. Biopsies of muscles, bones, and prostate in systemic infection reveal abscess formation with blastomycetes in the abscesses. In the case of the female, salpingitis and oophoritis may occur. General manifestations are often increased sedimentation rate and leukocytosis with a primary increase in the neutrophilic elements. Positive skin and complement fixation tests justify a presumptive diagnosis, although many times these are equivocal because of cross reactions.

If pus is found in the sputum, urine, or spinal fluid, the organisms may be demonstrated. These organisms occur as yeastlike or budding forms with a double-contoured refractile wall. If they are present, the diagnosis can be made without equivocation. Although in the tissue, the blastomycetes are found as round or budding yeastlike forms; and they can produce aerial-hyphae on Sabourand's media when incubated at room temperature. This distinguishes the infection from cryptococcosis or European blastomycosis, which retains its yeastlike characteristic on culture. The blood agar medium and the beef infusion glucose agar, at 37 degrees, produce wrinkled, waxy colonies. After animal inoculation of guinea pigs or mice with the blastomycetes in a saline suspension, the organisms will manifest themselves in systemic disease within 3 weeks, which will act as a confirmatory diagnosis to the cultural and microscopic findings of this fungus. A review of the literature reveals that in systemic blastomycosis the lung is involved in about 95% of the cases; the bones, primarily the vertebra and ribs, in 60%; the liver, spleen, and kidneys, collectively, in about 40%; the central nervous system in 30%; and the prostate in about 20% of the cases. Intestinal tract involvement is unusual, which differentiates this fungus disease from histoplasmosis.

Dr. L. E. McGary: Distribution of the organism is not known. In the dog the lung is commonly involved, and it would appear that soil is the natural reservoir. There are mycologists who believe that the disease occurs primarily in the lungs with the organism being subsequently disseminated to the skin, organs, and other tissues in the body. In this regard, it would appear that blastomycosis is similar to histoplasmosis and coccidioidomycosis. Person-to-person transmission is

extremely rare. Cases of mechanical transmission have been reported.

Lesions of the skin and mucous membranes of the fungating type may be confused with squamous cell carcinoma. In the lung the x-ray appearance may simulate chronic infection or bronchogenic carcinoma. Should there be necrosis and suppuration, the picture may be one of tuberculosis or abscess.

The object in presenting this case is to call attention to the fact that all granulomatous skin lesions occurring in agrarian patients should be biopsied and cultured for the diphasic organism *B. dermatitidis*, the natural distribution of which appears to be limited to North America. Cultural results can be markedly improved by the addition of some type of antibiotic to the media, as it facilitates the growth of the more fastidious strains. Virulence is variable and thus explains spontaneous recovery of a certain number of treated and untreated cases. The diagnosis of this condition depends on the proper clinical history, x-ray examination, biopsy, and culture of the lesion.

MILWAUKEE ACADEMY OF MEDICINE MEETING

TUESDAY, NOVEMBER 15—8:00 p.m.—University Club, Milwaukee

Speaker: Lt. Comdr. George W. Hyatt, MC, U. S. N., United States Naval Medical School, Bethesda, Maryland

Topic: "Transplantations"

WEDNESDAY, NOVEMBER 16—12:30 p.m.—Milwaukee Children's Hospital Special Clinic

WISCONSIN SOCIETY OF PATHOLOGISTS MEETING

The fall meeting of the Wisconsin Society of Pathologists will be held on November 12, 1955, in the Staff Room at Milwaukee Hospital, 200 West Kilbourn Avenue, Milwaukee.

The scientific program, a tissue seminar on "Diseases of the Reticuloendothelial System," moderated by Dr. R. Philip Custer of Philadelphia, will begin at 1:30 p.m. Members and guests will adjourn to the Ranch Room of the Boulevard Inn, 4300 West Lloyd Street, Milwaukee, where a dinner will be served. A short business meeting will follow.

UNIVERSITY OF MINNESOTA CONTINUATION COURSES

NOVEMBER 14–16—Bacteriology and Blood Bank Techniques (for medical technologists)

Open to all qualified medical technologists, the course is under the direction of Dr. Ellis S. Benson, Acting Director, Hospital Laboratories, University of Minnesota

NOVEMBER 21–23—Fractures (for general practitioners)

Management of fractures most commonly seen in general practice will be stressed. The course will include a demonstration session, and registrants are invited to bring x-rays from their own practices for consultation with members of the course faculty.

Under direction of: Dr. Wallace H. Cole, Professor, Department of Surgery, and Director, Division of Orthopedic Surgery, University of Minnesota Medical School

JANUARY 5–7—Obstetrics (for general practitioners)

Under direction of: Dr. John L. McKelvey, Professor and Head, Department of Obstetrics and Gynecology, University of Minnesota Medical School

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

COMPLICATIONS OF CHLORPROMAZINE THERAPY IN 800 MENTAL-HOSPITAL PATIENTS[1]

The relatively new drug, chlorpromazine, also known by the proprietary names "Thorazine" and "Largactil," is being studied extensively, both clinically and in the laboratory. The name "Largactil" was suggested as a play on words, to indicate that the drug possesses a large number of actions.

This drug is chemically related to Phenergan, one of the newer antihistaminics; yet, from the standpoint of action, it is entirely different and free from antihistaminic properties. Chlorpromazine is said to manifest "gangliolytic, adrenolytic, antifibrillatory, antiedemic, antipyretic, anticonvulsant and antiemetic actions," and is reported to be useful also in the treatment of shock. All these constitute a large and confusing group of actions.

Exploratory work is still in progress, both as to usefulness of the drug and as to liabilities. It is the possibility of harmful actions that should be recognized since there are many other drugs which, were it not for concomitant liabilities, might be very useful in some way or other. Drugs are like people in some respects. They may, and usually do, have a mixture of good and bad qualities. Even water, in overdosage, may be harmful.

The action of chlorpromazine on the cardiovascular system may produce tachycardia, pallor, and fall of blood pressure and thus become responsible for vertigo, muscular weakness, and syncope.

Its action on the gastrointestinal tract may cause dryness of the mouth and constipation, and a marked gain in weight, as indicated by the record of one patient who gained 70 pounds in a period of five months.

Frequency of micturition, or even urinary incontinence, occasionally occurs, apparently due to excess drug or to increased sensitivity.

The action of the drug on the central nervous system has produced a parkinsonian-like syndrome in a few instances; this has disappeared on reduction or cessation of drug taking.

Jaundice developed in over 1 per cent of a series of 800 cases studied and hence came to be considered an absolute contraindication to the use of the drug. Clinically, the jaundice was of the obstructive type. In the fatal cases, the liver was found to have a central necrosis, biliary stasis, and lobular atrophy; namely, a "subacute toxic hepatitis of blood-borne type."

Reactions in the skin occurred in approximately 3 per cent of the cases and consisted of one or other of two types: one, erythema, apparently the result of sensitivity to sunlight; the other a morbilliform eruption over the whole body. These reactions cleared up within a week or so independently of continuation or of cessation of drug taking. If edema appeared, drug taking was stopped temporarily.

Approximately 1 per cent of the cases developed epileptic fits during treatment, and all became free from fits when the drug was withheld. Most of these patients had a history of previous epileptic seizures.

In general, prior hypotension, hepatic dysfunction, and dyscrasias of blood are considered as contraindications to the use of the drug; and in instances in which these symptoms appear, the drug should be immediately withheld.

Finally, to top the list of undesirable reactions to chlorpromazine, it must be said that several deaths have occurred due to granulocytopenia, a reaction which is well known to be shared by several other drugs.
—A. L. TATUM, M. D.

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. . . . THE PRESIDENT'S PAGE . . . .

EVERY physician owes it to his community and to his patients to be well informed medically. Keeping up on the latest in medical research and advances is a necessity in the present-day practice of medicine.

Every physician worthy of the title doctor of medicine after his name knows this and strives to do his best to keep abreast of modern medicine. Here in Wisconsin, as members of the State Medical Society, we are extremely fortunate in having a year-round postgraduate education program available to us. The State Medical Society, in co-operation with the county societies and the medical schools of the University of Wisconsin and Marquette University, has done an outstanding job and has received national recognition for programs in postgraduate education.

Every time *The Wisconsin Medical Journal* is read one cannot help but notice the many fine postgraduate programs that have been arranged for the benefit of the practicing physician.

The year 1955 has been a fruitful one in this regard. In the Milwaukee area, an excellent postgraduate medical program sponsored by Marquette University School of Medicine on the application of radioisotopes was held on October 20, October 27, November 3, and November 10. On the postgraduate teaching circuit of the State Medical Society, meetings were held October 18, 19, and 20 at Rice Lake, Wisconsin Rapids, and Appleton; and in addition a school health conference was held at Medford.

A postgraduate program on physical diagnosis at Marquette University will be held on six successive Wednesdays beginning December 7 and concluding on January 18. The State Medical Society plans additional programs in January and February as follows: January 17—Richland Center; January 18—Oconomowoc; January 19—Sheboygan; February 14—Janesville; February 15—Stevens Point; and February 16—Green Bay. Marquette University plans two or three more postgraduate programs to be held in the late winter and early spring months.

The annual fall clinic held at Marquette for medical school alumni on October 29 was a tremendous success, with teachers from the preclinical science department presenting an excellent program. Programs of this nature are planned frequently by both Marquette University and the University of Wisconsin.

In addition, most county medical societies arrange to have quarterly or monthly meetings at which a scientific presentation is made on some subject of general interest to members. These meetings are important to county medical societies in their postgraduate programs.

November 14–17 are the dates of one of the most important medical meetings ever to be held in Milwaukee. The Interstate Postgraduate Medical Association of North America will present an International Assembly at the Milwaukee Auditorium. A compact and complete program which will attract the interest of every practitioner in the State of Wisconsin has been arranged.

I can only urge you as a member of the State Medical Society to avail yourself of these excellent opportunities which help to bring you up to date on the latest in medical science.

The physicians who have taken the initiative in organizing these worth-while seminars and courses are to be congratulated. A good attendance at these meetings will not only show our appreciation but will also show our concerted interest in continuing these educational programs.

Erwin L. Bernhart M.D.

THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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Volume 54 OCTOBER 1955 Number 10

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A Pound of Preparation

The efforts of the Council on Medical Service of the State Medical Society and several state and private organizations add up to far more than the proverbial "ounce of prevention" in the field of first aid for illness and accidents. Actually, it is preparation rather than prevention for the obvious reason that prevention has failed or there would be no need for first aid.

First, there was the publication by the Council on Medical Service of a chart outlining recommended procedures for first aid. This attractive chart, designed to fit on the inside of the household medicine cabinet or to fold within the automobile first aid kit, offers helpful tips on what to do while getting the patient to a doctor. Thus far, nearly 200,000 copies of the first aid chart have been distributed in Wisconsin; and both California and North Carolina medical societies have copied it for widespread distribution there.

Second, was a survey by the Council on Medical Service to determine the availability of physicians, day or night, in every community of Wisconsin. This detailed analysis of availability revealed that virtually every physician or hospital in Wisconsin has made some kind of appropriate arrangement for medical care, night or day, seven days a week. As important as that finding of fact, was the recommendation of the Council to the public that they establish contact with a personal physician to prepare themselves for any emergency and, if an emergency develops, that they contact their personal physician first. If he is unavailable, they should contact the nearest hospital.

Third, was a joint development by the State Medical Society, the State Board of Health, and the State Highway Department of a special section on the 1955 highway maps offering advice on what to do in an emergency and indicating the location of every general hospital in Wisconsin.

Fourth, the Council, in cooperation with the Wisconsin Division, American Automobile Association, offered first aid advice and information on the location of hospitals in one of the A.A.A.'s travel guides for Wisconsin.

Fifth, at least one and perhaps several publishers of literature for visitors to Wisconsin's north woods distributed thousands of brochures which included the names of local physicians, dentists, and hospitals as an aid to the traveler who has met with the unexpected.

Illness and accident are never anticipated. The average traveler, in a high state of relaxation and enjoyment, is the least prepared to cope with emergency. These efforts to disseminate first aid information and speed the rendering of medical care are impressive steps toward safer, happier living in Wisconsin. It is good to know that, should an ounce of prevention fail, someone has been thoughtful enough to offer a pound of preparation.

What About Your Medical Assistants?

For a number of years, the American Medical Association has emphasized the tremendous importance of the doctor's assistant in creating good public relations. The Association published and supplied to each of its members a handbook on doctors' aides two years ago entitled "Winning Ways With Patients." It has furnished literature and suggestions to medical societies conducting public relations and training courses for office aides. It has developed packets for meetings of medical assistants.

It is the feeling of the Association that medical assistants or medical secretarial groups are composed of sincere women who are anxious to put their activities in the doctors' offices on a more professional plane of efficiency.

Stemming partly from the realization by physicians that properly trained office personnel can do much to keep patients happy and partly from the desire of doctors' assistants to improve themselves and increase their professional stature, a movement toward the establishment of organizations of medical assistants is under way. The most recently organized group, the Wisconsin State Medical Assistants Society, was established here in Wisconsin last June. It is important for every physician to know about this group since his nurse, secretary, or technician may be asked to join a group if she isn't already a member.

It is quite likely that the doctor's employee will ask his advice before she joins the society. Before giving a "yes" or "no" answer, it would be well for the physician to know these facts:

1. The Wisconsin State Medical Assistants Society has been approved by the Council of the State Medical Society.

2. The purpose of the society is to unite in an organization those members who are employed in offices of members of the State Medical Society of Wisconsin and others who are employed in hospitals approved by the Joint Commission on Accreditation of Hospitals and in medical laboratories in the State of Wisconsin. Further, it is organized to inspire its members to render honest, loyal, and more efficient service to the profession and the public which they serve; to render educational services for the self-improvement of its members; and to stimulate a feeling of fellowship and cooperation among members.

3. Physicians themselves play an active part in the governing of the group since the Council on Medical Service of the State Medical Society serves as its advisory body.

With this firm foundation, the Wisconsin State Medical Assistants Society is seeking the cooperation of physicians in encouraging their medical assistants to join the state organization. The women currently holding membership in the organization are enthusiastic over its future and what the association can mean in added efficiency and satisfaction for its members. Following patterns developed elsewhere, the Wisconsin Assistants group intends to concentrate on projects such as educational courses in medical and socio-economic affairs; meetings to help assistants develop better understanding of health insurance; aiding the physician in public relations programs such as the distribution of literature; and, most important of all, programs for improving individual charm, good grooming, telephone techniques, public relations, and office procedure and management. Although every physician bears the responsibility of explaining his own routine to his employees, most doctors welcome help in getting across to receptionists and others who share the daily round of practice the basic differences between mediocre methods and attitudes and truly effective procedures. An organization of medical assistants with the proper motivation and guidance can contribute substantially to this end.

Recognizing legitimate desires of their employees and acknowledging the work of adequately trained assistants, physicians can do much in shaping the pattern of medical assistants organizations if they will take the initiative or will proffer their cooperation when it is sought.

Thanks to 495

It is always gratifying to see the voluntary response of the medical profession to appeals for worthy causes. Perhaps this is especially true when the cause is one "within the family," so to speak. The appeal of the Charitable, Educational and Scientific Foundation, Inc., of the State Medical Society of Wisconsin has resulted, thus far, in contributions from 495 physicians totaling $5,670. Contributions to this foundation can be particularly important because the organization itself is fluid and can provide for educational, charitable, and scientific works, wholly under the direction of physicians, in fields where other funds may not be available but where worthy purpose exists. Already, for example, $2,900 of the total contributions to the Foundation is on loan to needy medical students. To the 495 contributors, the foundation's officers express their thanks. To the several hundred other active members of the Society over 35 years of age who have not yet contributed, the officers respectfully urge reconsideration and express the hope that $10 might not seem too much for the profession's own.

MILWAUKEE GYNECOLOGICAL SOCIETY MEETING

MONDAY, NOVEMBER 28, 1955 . . . 8:00 P. M.
WISCONSIN CLUB
900 West Wisconsin Avenue, Milwaukee
"The Surgical Management of Ovarian Tumors"

JOHN L. PARKS, M. D.—Professor of Obstetrics and Gynecology, George Washington University School of Medicine, Washington, D. C.

THE MEDICAL FORUM

COUNCIL OKS CANCER TEST PLAN IN WISCONSIN

4 or 5 Counties To Be Selected For USPHS Project

Madison, Oct. 14—A U.S. public Health Service plan to study cancer incidence among women in four or five Wisconsin counties was endorsed by the State Medical Society's Council.

Counties have not yet been named. The plan is expected to provide tests for 160,000 women, starting early in 1956. The sanction of county medical societies in each area is required.

Technicians will be trained for the program by the USPHS, working with the state laboratory of hygiene, under Dr. W. D. Stovall, in Madison. Also cooperating will be the University of Wisconsin Medical school.

Technicians will study smear tests to determine the presence of cancer of the cervix or uterus. All women over 20 years in the counties selected will be urged to see their personal physicians to have the tests made.

SEVERAL OBJECTIVES

The proposed study has these objectives:

1. To determine the prevalence or incidence of cancer in the rural population of several Wisconsin communities.
2. To determine and demonstrate the most practical procedure for bringing these examinations to rural women through doctors' offices.
3. To extend the use of test smears for the discovery of early cervical and uterine cancer by rural practicing physicians.

The Council met in connection with the dedication of the new home of the State Medical Society in Madison.

SET UP SAFETY UNIT

In other action, the Council:

Established a Committee on Health and Highway Safety, and named Doctor Gearhart, Madison, chairman. Immediate concern of the group will be health aspects of the driver licensing system, accident reporting, effect of vision, hearing and aging on collision rates.

Reported the Society's Charitable and Scientific Foundation had received $5,660 from 493 physicians to conduct special studies in the scientific and insurance field.

Reported the Society's Student Loan Fund had allocated $6,060 to Marquette University School of Medicine and $10,750 to University of Wisconsin Medical School students in need of financial assistance.

Student Loan Fund Allocates $13,910 Since June, 1953

Madison, Oct. 31.—The Student Loan Fund of the State Medical Society of Wisconsin, still an infant project in years of activity, has allocated $13,910 since June, 1953.

Of this total, $7,850 went to 10 students attending the Wisconsin Medical School, and $6,060 to 11 others enrolled in the Marquette University School of Medicine.

Loans ranged from $100 to $1,000, the maximum annual amount. Two applications from U. W. students are pending. An additional $2,900 was allocated by the Society's Charitable, Educational and Scientific Foundation Inc.

The Student Loan Fund grew out of an idea advanced by Dr. H. H. Christofferson, of Colby, at his inauguration as Society President in 1950. The Fund was organized in 1951, with a goal of $250,000 to provide assistance to needy and deserving medical students.

A responsibility of a board made up of seven trustees, the Fund is derived from contributions forwarded by Society members.

The U. S. Public Health service recently announced 10 grants totalling $295,367 to start a special program of research into air pollution problems.

AAA BOOKLET LISTS HOSPITALS, FIRST AID TIPS

Washington, Oct. 17—For the first time in its many years of publication, the American Automobile Association's pamphlet, "Where to Vacation in Wisconsin," carries a list of Badger State general hospitals.

Acting on request of the State Medical Society of Wisconsin, the AAA included the list of 102 institutions.

Also prepared and approved by the State Society was another feature, "First Aid Suggestions," covering two pages in the widely-distributed booklet, a catalogue of travel information.

Urge MD's to Enroll In Own Insurance Plan

Madison, Oct. 24—Wisconsin physicians were reminded today that annual enrollment for their own Blue Cross-Blue Shield coverage is scheduled for November.

Last year a special plan was created for State Medical Society members engaged in active practice. Annual enrollment will take place next month with coverage effective Dec. 1.

The plan enables Society members, other than those in Milwaukee County where a special arrangement with Surgical Care is in effect, to purchase Blue Cross and/or Blue Shield for themselves and their families without a health questionnaire.

A letter will be sent to physicians this week, explaining available coverage and cost. Application cards must be forwarded to Society offices in Madison along with a semi-annual payment by Nov. 15 for coverage effective Dec. 1.

Physicians who fail to enroll in November—new members excepted—cannot enroll until next fall.

UW MED DEAN REPORTS ON TRENDS, ENROLLMENT

Madison, Oct. 24—Dean John Z. Bowers, reporting a new freshmen class of 84 in the University of Wisconsin Medical School this fall, commented recently on a change in the base of pre-medical education.

"In the past," he said, "medical students were selected primarily on the basis of high grades in undergraduate science courses, particularly organic chemistry, physics and zoology.

"Today, there is a trend toward broadening the base of our education, and the Medical School is interested in applicants whose education has been rounded out by studies in the humanities, languages and history, in addition to the scientific courses.

"The new viewpoint toward a broader preparatory education harmonizes with a current trend in business and industry which also is seeking men with a liberal arts education in belief that the so-called 'flexible man' makes a better executive than a specialist does."

NEW WING AT SCHOOL

For those who make the grade, what kind of doctors do they become these days?

Dr. Bowers said:

"It is untrue that people today do not have a family physician who acts as a health advisor. We still have the old time general practitioner only with a different name. He is often the pediatrician or internist fulfilling the same role."

The dean, serving his first year at the state university, said a new wing, now under construction, would bring the department of anatomy into the medical center for the first time. Also, it would provide some improved teaching facilities for physiological chemistry.

Train 2,881

The newcomers to the school follow in the footsteps of 2,881 men and women who have been trained at the U. W. for the practice of medicine since the inception of the Medical College 47 years ago.

The freshmen form a small group who will receive intensive personalized training at the hands of the medical faculty, many of whom are specialists in the University Hospitals, in Madison and Milwaukee. They will spend four years in medical school with additional service as interns and residents before they begin actual practice.

Dr. Bowers estimated that each of the 84 newcomers would spend about $15,030 in gaining a four-year education, a figure which is the national average for a medical education.

ADMISSION POLICIES

The freshmen, who come with their hearts set on this career, were selected by a careful screening process which placed a premium upon top scholarship in undergraduate studies. Each student was approved and recommended to Dean Bowers by an admissions committee. A minimum B average may carry a student into the freshmen class if he brings recommendations of fine character and strong motivation. And extra-curricular activities help, too.

Dr. Bowers said some "late-maturing" students, whose scholastic standings are comparatively low in early undergraduate work but show a vast improvement later on, often provide the best medical school material.

The number of women accepted varies from year to year. The School now has five freshmen women, nine sophomores, two juniors and 11 seniors. Most of them indicate a preference for pediatrics, public health and obstetrics.

Failures vary from 3 to 10 per cent. Wisconsin students are given opportunities to remain in school, including probation and repetition of courses when necessary.

AMA REPORT

A report filed by the AMA stated that American Medical schools set all-time enrollment and graduation marks in 1954–55. They face, however, a student recruitment problem in the next few years.

The AMA's Council on Medical Education and Hospitals said the past term was one of steady progress in various phases, although applications to schools have been slumping since 1950.

The report said only 16.8 per cent of the entering class in 1954–55 had an A college record, while 69 per cent had B averages and 14.2 per cent had C.

Almost 7,000 physicians were graduated last June from 75 approved four-year med schools. This is 1,400 more than in June, 1950.

Dr. Bowers

The Class of 1956 is expected to be smaller. However, seven more schools will be graduating MD's by 1960. Only one, The University of Missouri School of Medicine, is in the midwest.

Seventy-three per cent of the June, 1955, class was liable for military service.

Total medical school enrollment in 1954–55 was 28,583, an increase of 356 over 1953–54.

A "modest improvement" in medical school financing was noted in the AMA report. Estimates for 1955–56 indicate that outside agencies will contribute about $54,500,000 for support of research activities and $7,000,000 for special teaching programs. Another $98,000,000 will come from endowment income, tuition, legislative appropriation, gifts, and grants.

During 1954–55 completed construction by medical schools aggregated more than $99,000,000, with construction initiated totalling more than $80,000,000. In addition, many hospital and clinic facilities used in teaching were financed by governmental or private funds and not by the schools.

The report also showed:

There were 251 faculty vacancies this fall.

There are 1,537 women attending medical schools; 345 were graduated in June.

More than 105,000 attended short courses, assemblies, seminars, study and circuit courses for practicing physicians wishing additional training. This was a record year.

McROBERTS, PAWSAT, ROSS, TORMEY TO STATE BOARD OF MEDICAL EXAMINERS

Madison, Oct. 4—Four appointments to the Wisconsin State Board of Medical Examiners were announced by Gov. Kohler.

The appointments:

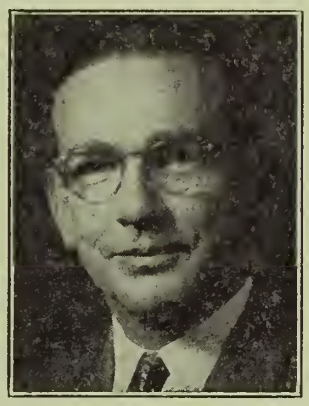
Dr. Jerry McRoberts, Sheboygan, to succeed himself for a term ending July 1, 1959. President of the Sheboygan County Medical Society in 1953, he served as chairman of the State Medical Society's Section on Surgery in 1951–54 and was a member of the Society's Cancer Committee in 1950. Dr. McRoberts is on the active staff of the Sheboygan Memorial and St. Nicholas hospitals. A native of Moose Jaw, Saskatchewan, Canada, he was graduated from McGill University in 1929. He is 49 and a specialist in surgery.

Dr. Thomas W. Tormey jr., Madison, to succeed himself for a term ending July 1, 1959. He is chairman of the State Medical Society's Commission on State Departments, a former delegate to its House of Delegates and a member of the Committee on Resolutions, Hospital Relations and Grievance committees. A specialist in urology, Dr. Tormey is 46, a graduate of the University of Washington Medical College and an active member of the Dane County Medical Society. He is on the staffs of the Madison General and St. Mary's hospitals.

Dr. Ewald H. Pawsat, Fond du Lac, to succeed Dr. Alvin G. Koehler, of Oshkosh, for a term ending July 1, 1959. A specialist in pediatrics, Dr. Pawsat, 47, is chairman of the School Health Division of the State Medical Society's Commission on State Departments and of the Pediatric Section of the Society. Past president of the Fond du Lac County Medical Society, he is immediate past chairman of Physical Health, Wisconsin State Parent-Teacher Association. A graduate of the University of Cincinnati School of Medicine, Dr. Pawsat served more than three years in the U. S. Navy during World War II.

Dr. Fordyce A. Ross, Milwaukee, to succeed Dr. J. W. Prentice, Ashland, for a term ending July 1, 1959. A general practitioner, he has been a member of the State Medical Society since 1937. Dr. Ross, 44, was graduated from Marquette University in 1936 and interned at St. Joseph's Hospital in Milwaukee. He is a navy veteran of World War II. He is married and the father of three children.

Dr. J. McRoberts



Dr. T. W. Tormey, Jr.

Dr. E. H. Pawsat

Dr. F. A. Ross

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All Hail to Sweetpea, Star Deluxe At SMS Dedication Day Doings

Madison, Oct. 31.—Cited as the brightest example of human interest and color at the State Medical Society's dedication weekend was the "horse 'n buggy doctor."

Star of the feature display was Flashlight–Peavine, a revered SMS member, equine division. (His better known name is Sweet-Pea.)

When guests and members drove up the road leading to the new building, officially dedicated Oct. 15, they saw Sweet-Pea harnessed to an old buggy, circa 1900. In the driver's seat was "Doc," recently enrolled into the organization. His presence is expected at numerous Society functions in the future, but how much actual voice he'll contribute remains a mystery.

Sweet-Pea has a remarkable background. His life story was traced to birth in Reedsburg 70 years ago, where he had several owners, most of them harness shop operators. In 1941 he was brought to Madison on loan for display at the SMS Centennial festivities. It was decided to buy him, inasmuch as freightage charges exceeded the amount asked for the stallion.

One of the custodians of the beloved life-size replica of Swaps was Dr. T. A. Leonard, Madison obstetrician. He (Sweet-pea) was confined in several stalls. Even Mr. Charles H. Crownhart, SMS Secretary, had a turn in standing guard for awhile.

Never a winner of the Kentucky Derby, the Pimlico Stakes or the Santa Anita Handicap, Sweet-Pea, nevertheless, has many friends and backers. There is no worry re charley horses, bloat, colic, spavin, ringbone, shoeboil, distemper or the like. He is impervious. He is solid.

Woe to anyone who harms Sweet-Pea, definitely and surely, a major member of the cast engaged in SMS traditional aspects.

Hail to the star!

A number of Dedication Weekend programs remained after the ceremonies were completed Oct. 14–15. SMS members are invited to write in for a copy. The programs document the organization's history, lists its officers and contains the official program and pictures. Just send a note to Jack Burke, Public Information Div., SMS, P.O. Box 1109, Madison, and one will be sent promptly.

AMA Clinical Session To Bring 4,000 to Boston Nov. 29–Dec. 2

Boston, Oct. 31.—The AMA expects its Nov. 29–Dec. 2 clinical meeting to be the biggest ever.

The postgraduate education session, aimed at solving the daily practice problems of the family physician, has attracted a registration of 4,000 persons. More than 2,000 scientific papers and exhibits have been prepared.

Closed circuit television programs, originating in New England Deaconess hospital, will bring live operations in color to the lecture hall.

The General Practitioner of the Year will be named during the meeting. Dr. Karl Pace, Greenville, S. C., was named in 1954.

CHLORDANE REPORTS AVAILABLE AT AMA

Madison, Oct. 22—Reprints of recent reports entitled "The Present Status of Chlordane" and "Fatal Chlordane Poisoning" are available at the AMA office in Chicago, the organization's committee on Pesticides reported.

Dr. J. B. Amberson to Be Dearholt Days Speaker in Wisconsin

New York City, Oct. 22—Dr. J. Burns Amberson, professor of medicine emeritus at Columbia University, will be the Dearholt Days speaker in Milwaukee Nov. 7 and Madison Nov. 8.

His return to Wisconsin marks the 15th anniversary of his inauguration of the lectures of the Wisconsin Anti-Tuberculosis Association.

Dr. Amberson is a past president of both the American Trudeau Society and the National Tuberculosis Association. He now is a consultant in the chest service of the Bellevue and Presbyterian Hospitals in New York.

His talk before the faculty and students of the Marquette University School of Medicine will be on the subject "The Behavior of Tuberculosis Under Present-Day Treatment." He will speak on the same subject to the faculty and students of the Wisconsin Medical School the next day. In the evening of Nov. 8 Dr. Amberson is scheduled to address the Dane County Medical Society on "Prompt Diagnosis of Pulmonary Disease." Guests from other societies were invited.

Dearholt Days are sponsored yearly by the WATA in memory of its founder, Dr. Hoyt E. Dearholt, and his interest in medical education.

Horse and buggy doctor reduplicated for the Society dedication.

PREPAID PLANS COMMISSION SEEKS COVERAGE CHANGE

Liberalization of Underwriting Policy Is Major Goal

Madison, Oct. 31.—The Society's Commission on Prepaid Plans has commended Wisconsin Blue Cross for its recent liberalization of underwriting policies. It also offered to hold Blue Cross harmless on certain contestable claims as an inducement to further broaden coverage.

These actions came about as a result of joint studies between Blue Cross and Wisconsin Physicians' Service. These revealed that non-group applications placed heavy burdens on many subscribers by permanently ridering-out conditions or excluding individuals from coverage.

In September, the Commission was informed of an Associated Hospital Service Inc., proposal to limit the duration of riders placed on such contracts. Under the proposal, medical judgment will play a major role in the determination of the period for which the rider will be effective. Such liberalization of the underwriting procedures was authorized by the Society group.

Information relating to the Commission action was forwarded to officers and staff members of the Blue Cross plan.

The resolution stated that Blue Cross had indicated it would revise its policy to limit the period under which riders may be applied, "thus producing a more realistic evaluation and encouraging the expansion of Blue Cross and Blue Shield in the field of non-group coverage."

It also stated:

"Blue Cross also recently liberalized its policy by placing a three-year limitation on contestability of claims for pre-existing conditions instead of the indefinite period theretofore existing.

". . . WPS Blue Shield, as to the latter point, and since 1952, has used a one-year contestability applicable to misstatements, except fraudulent statements, and in its analysis . . . has determined such provision to be medically and statistically sound.

". . . It is desirable in the interest of the public and in furtherance of the purposes of Blue Shield and Blue Cross to be as liberal as possible, . . . so be it resolved:

"That WPS offer to enter into an agreement with Blue Cross to hold the latter harmless for a specified period of experiment and observation as to all claims which it would have disallowed because of its three-year rule and which Blue Shield pays under its one-year rule."

Rock County Medical Assistants Organize

Janesville, Oct. 26—Esther Bittrich, of Beloit, was elected president of the Rock County Medical Assistants' Society at an organization meeting recently.

Miss Bittrich is an employe of Dr. H. E. Kasten.

Others elected:

Audrey Holtshopple, Janesville, president-elect; Audrey Crawford, Janesville, recording secretary; Mrs. Myrtle Gettman, Beloit, corresponding secretary and Mrs. Jane Cummings, Janesville, treasurer.

Committee chairmen include Wilma Fanning, Janesville, program–social; Virginia Eller, Janesville, publicity and Mrs. Carolyn Hefty, Beloit, membership.

Members in attendance approved a constitution and by-laws, and Miss Holtshopple, recording secretary for the Wisconsin State Medical Assistants, reported on the state program. The county group will be affiliated with the state organization shortly.

The group, which will meet monthly, will include all physician assistants, nurses, clerks, receptionists, technicians secretaries and others employed in medical offices in Rock county.

More 'n More MD's Learning to Fly Own Plane, Check Shows

Madison, Oct. 29—A quick check of State Medical Society of Wisconsin members who fly their own airplanes brought out several surprises.

First it was learned the number is over 100, a remarkable figure when one considers the membership of 3,200.

The figure does not include others who have planes on call for use in emergencies.

Dr. D. E. Dorchester, Sturgeon Bay, is a licensed pilot, and recently recalled making a house call in Louisiana. The patient was a former Sturgeon Bay resident. More often, the plane is utilized to make calls on Washington Island.

Another, Dr. L. O. Simenstad, of Osceola, Society President-Elect, frequently takes charge of the stick to fly to meetings and visit patients. He has been a member of the State Aeronautics Commission since its inception in 1945.

Dr. Herman A. Heise, Milwaukee, takes to the air to make studies of atmospheric conditions and the like for his work in allergies.

There are many others who make good use of air travel to expedite their medical care and treatment procedures.

One more great honor came to La Crosse's Dr. Gunnar Gundersen in October: He was elected vice chairman of the Council of the World Medical Association at its recent meeting in Vienna, Austria.

PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
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Our helpful brochure
"How to Make Your Practice More Successful"
available on request.

MURPHY ADVISES: SEEK HELP IN TAX MATTERS

SMS COUNSEL SPEAKS TO AMA SYMPOSIUM

Chicago, Oct. 26 — Robert B. Murphy, counsel for the State Medical Society of Wisconsin, urged physicians to seek advice of attorneys and other qualified experts in general financial consultation and income tax matters.

He spoke at the AMA's first Medicolegal Symposium. His subject was *"The Professional Man as a Taxpayer."*

Murphy said:

"Know enough to know that the federal income tax law must be taken into account in virtually any type of transaction at the present time. Then get competent assistance so as to minimize the tax aspects of those transactions.

Physicians need:

"*An attorney,* both for general consultation and tax advice. The two should be considered jointly because in many situations a client has a choice of legal courses open to him which will substantially reduce his tax liability.

"*A CPA* as a tax consultant . . . not only to establish and supervise your records, but to work with your attorney in preparation of returns and joint handling of your tax affairs. With the attorney, a CPA can work as a team.

"*A business administrator* for a large practice, particularly if several physicians are engaged in it, either as partners or salaried associates. A smaller organization needs a business consultant who, if qualified, can supply some of the services other than that of the attorney and accountant. If such consultants claim they are handling either your legal or accounting work, I would recommend you investigate and prepare to replace them.

"The complexities of the income tax law are such that in addition to the counsel and CPA you may need expert aid on your investments, on insurance, on the value of your real estate, including an office or clinic building, and the advice which experienced *trust officers* can give. Your attorney is the man who should put you in touch with these specialists when and as they are needed.

Atty. Robert B. Murphy

"A doctor needs *a coordinator,* and that had better be an attorney . . . just as a family doctor calls in a specialist for a particular patient."

Murphy also recommended that physicians "consider carefully how you feel about coming under the social security law." He continued:

"Don't try the free ride. Approach slowly. From many points of view its (The SS law) benefits are more apparent than real.

"Write your congressman on the Jenkins–Keogh–Ray bills. They would give tax parity or equality to you, attorneys and other self-employed in the basic matter of savings and personal retirement programs.

"Make it your business to know your senator, your congressman, your state representatives and your local government representatives. Whether you like it or not, government has become a vast business which dwarfs any other.

"As heavy taxpayers and as the special beneficiaries of a heavily subsidized educational system, professional men have corresponding obligation to be *active and intelligent* citizens. *They cannot be either without first being well-informed.*

"Only if physicians and other professional men will interest themselves in our tax structure, including the social security and related systems, will they be able to fulfill their obligations as citizens and at the same time exercise some possible reasonable controls over a tax system which could engulf them and our economy if it is allowed to grow beyond the critical point."

The SMS counsel quoted Chief Justice John Marshall, "who wrote with rare insight nearly 150 years ago—'The power to tax is the power to destroy.'

"The planners know this. Do you?"

Attorneys from all sections of the midwest attended the symposium, with a registration close to 300. Similar sessions were held in Omaha and New York City in October; all with the goal of improving an understanding of medical and legal professions.

ON THE SMS CALENDAR . . .

November

3—Industrial Health Committee, SMS.

7–8—State Medical Journal conference, Chicago.

12–13—Conference of County Medical Societies Civil Defense Organization, Chicago.

14–17—Interstate Postgraduate Medical Association Association of North America Conference, Milwaukee.

16–17—Interstate, Wisconsin Public Health Council, Milwaukee

18–19—Conference of Mental Health Representatives of State Medical Societies, AMA–Chicago.

19–20—North Central Conference, St. Paul.

29–Dec. 2—AMA Clinical Meeting, Boston

December

1—Wisconsin Welfare Council, SMS.

Claims Committee, SMS.

3—Basic Science Exams, Milwaukee

6—Claims Committee, SMS

10–11—Commission on Prepaid Plans, SMS

15—Council on Medical Services, Milwaukee.

17—School Health Conference, La Crosse.

23—Division on Nervous and Mental Disease, Milwaukee.

Division on Tuberculosis and Chest Diseases, Milwaukee.

IS YOUR HALO ON STRAIGHT?

The accompanying cartoon is from a new booklet published by the San Lucas Press, Los Angeles. It has stirred up wide interest because of its pointed dealing with certain conditions which could exist in the medical profession. Editors are members of the Ethics and Professional Conduct Council of the Alumni Association, School of Medicine, College of Medical Evangelists of California.

The Forum section of *The Wisconsin Medical Journal* will reprint cartoons from the booklet during the coming months. Copies are available from the San Lucas Press, with discounts depending on quantity ordered.

USES HUMOR

Editors said the booklet was aimed at medical students and beginners in the profession rather than a blast at exisiting practitioners.

The brevity and wit of the publication aided in making it a hit, wherever seen. LIFE magazine picked it up and devoted a full page to its message.

Using the classical devices of caricature, humor and ridicule, HALO makes a few points briefly and without pulling punches, hoping to make beginners particularly beware, to hedge them about, to help them from slipping.

It should prove a valuable aid in efforts to foster medical ethics and professional conduct.

Your colleagues, your patients and the public have you under glass. You're a doctor, son—and they expect you to act like one.

If you are young, freshly starched by a rigorous residency and eager to win patients and influence friends, your personal and professional decorum will be exemplary.

The wolf at the door will see to that.

But what of the future when symptoms of security begin to appear? Will you then spend more time polishing your scalpel than your character?

Chances are good that you won't. Most doctors settle down to being doctors, with all that the name implies.

A few of them don't—and while we can't condone their straying from the norm we must confess we're indebted to them.

Not only did they give us a reason for this booklet—they also serve as its specimens. Any resemblance to persons living or dead, is of course, so much the better.

URGE FULL MED CARE FOR 6-MONTH GI's

Washington, Oct. 29.—The National Security Training Commission has recommended increasing substantially medical officer requirements of the Army and Navy.

The recommendation must be approved by Secretary of Defense Charles E. Wilson.

The Commission's report urged that six-month trainees in military's new reserve program receive hospitalization, medical, surgical and dental care "in the same manner presently furnished for armed forces in general."

Another point sought retaining recruits beyond their training period—with their consent—for continuation of medical care of illness or injuries originating while they are in uniform.

With military medical departments facing high attrition rates in 1956, in the matter of doctors fulfilling service obligations, it is apparent replacement figures must be revised upward if trainees are to receive health care benefits identical to those enjoyed by longer-term personnel.

Secretary Wilson also is expected to rule on eligibility for dependents medical benefits.

The commission said the proposed services will "mean a marked improvement in personal health and hygiene of some of the trainees. Some never have consulted a doctor, prior to induction. It is hoped this will encourage the practice of seeing their doctor regularly once they leave training."

Poll Shows Most Farmers Feel MD Fees Reasonable, Service Good

Racine, Wis., Oct. 31.—A poll taken by the Wisconsin Agriculturist and Farmer showed most farmers don't complain too much about doctor fees. Some, however, said they wish the MD's had time to take more of a personal interest in their patients.

In an article written by W. C. Voskuil, the semi-monthly stated most rural residents have both praise and criticism for the medical profession.

Regarding personal interest, 47 per cent said the doctors do all right. Another 15 per cent said they take too little interest and another 48 per cent said "some do, some don't."

Fifty-seven per cent of the farmers interviewed said fees were reasonable. Charges were described as "not reasonable" by 35 per cent, with the remainder stating "don't know."

A DISSENTER . . .

(The following appeared in Letters to the Editor in the Wisconsin Agriculturist and Farmer)

I don't agree with your poll . . . where you say 57 per cent of the farmers think doctors' fees are reasonable. Or that 47 per cent feel that doctors take a personal interest in them.

Baloney! Most doctors will take you for every dime you have and more, too. The only time they take an interest in you is when you come to pay a bill!

Do you have a lot of doctor friends—or what?

—One Who has Paid Through the Nose, Waupaca County

In general, women rated doctors higher than did men.

One man, however, said:

"How can I complain about the family doctor when the vet charges more than the doctor does for a farm call?"

His feminine counterpart declared:

"Doctors have a nerve-wracking job, requiring lots of education and experience. They ought to be making good money."

One feminine rural resident exclaimed:

"Doctors! I think they take one look and try to figure just how much they can soak you!

Specialists also came in for some hostile words. One Sauk county man said:

"They really stick it in you for the small amount of time they put in."

Everybody seemed to agree that doctors are too busy. Many mentioned that more physicians are needed. Several ladies said:

"It's surprising that doctors take as much interest as they do considering the load they have to carry."

The poll revealed that older farmers were more critical of the treatment they received than were the younger ones. Of those over 50, only 45 per cent were happy with the interest shown by MD's. Those younger—52 per cent of them anyway—said things were fine.

Most persons interviewed said, "our own doctor is a good guy, but some city specialists—all they are after is the money."

Voskuil summed up things by saying "the family doctor rates pretty well with Wisconsin farm families. There are plenty of complaints but farmers still think highly of their doctor."

Los Angeles Society Plans Convention; Dr. Hess to Speak

Los Angeles, Oct. 11—The Los Angeles County Medical Association, commemorating its 85th anniversary, will stage a Midwinter Medical Convention Jan. 3–5 to stress major developments in science.

Dr. Ewing L. Turner, LACMA president, said particular attention would be paid to geriatrics, preventive medicine, atomic medicine, blood and blood products, neoplastic diseases and chemotherapy.

Guest speakers will include Dr. Elmer Hess, Erie, Pa., president of the AMA.

Convention planners said visitors would be able to witness the Rose Bowl game New Year's Day, the Rose Parade Jan. 2 and then attend the sessions.

Following the convention, the public Cavalcade of Health and Medical Progress will be held Jan. 6–15 in Los Angeles.

MD's Urged to Check Hunting Regulations

Madison, Oct. 25—Are you acquainted with the laws covering hunting in Wisconsin?

Not a few hunters go afield without a good knowledge of what is legal and what is unlawful.

To clarify the situation, the Wisconsin Bar Association this week issued a set of do's and don'ts. These included:

Don't hunt on land enclosed by a fence and used as pasture for stock, or enter upon enclosed or cultivated lands or woodlots without permission of the owner or occupant.

Don't attempt to hunt on any posted land, or enter standing grain with firearms or permit any dog to do so without permission.

Do take time to obtain permission for hunting on any privately-owned lands, even if not enclosed or posted.

Do check on local and state regulations. Trespassers and violators are subject to fines, jail or confiscation of firearms.

Don't have your outing ruined. Be safe, not sorry.

Would you like a color print (large enough for framing) of your new SMS home in Madison? Send a card or letter to Box 1109, Madison, and one will be on its way to you shortly.

UW Med Students Map Externship Study

Madison, Oct. 27—The Wisconsin Students' Medical Association reported in its October *Bulletin* plans for a committee to evaluate the externship program.

Findings already submitted to the WISMA indicate, the article stated, that:

Certain inequities exist among the various preceptorships in that some provide room and/or board, or similar aid, while others provide little or none and place a burden of expense on the student.

Room for improvement and standardization exists.

The *Bulletin* explained the added expense often is met with money from an "insurance" fund derived from contributions by juniors. This money is allocated to those assigned to the more frugal locations.

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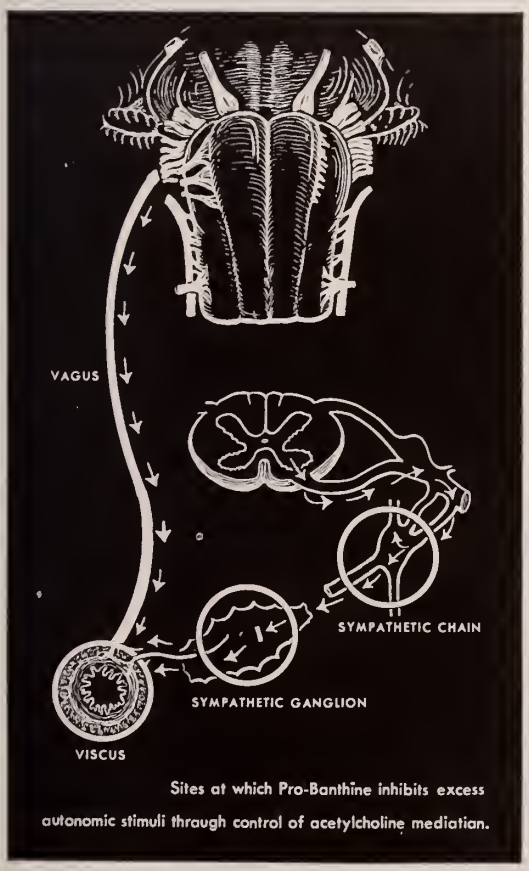

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For the average patient one tablet of Pro-Banthine (15 mg.) with each meal and two tablets (30 mg.) at bedtime will be adequate. G. D. Searle & Co., Research in the Service of Medicine.

---

1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: Gastroenterology *25:*416 (Nov.) 1953.

2. Roback, R. A., and Beal, J. M.: Gastroenterology *25:*24 (Sept.) 1953.

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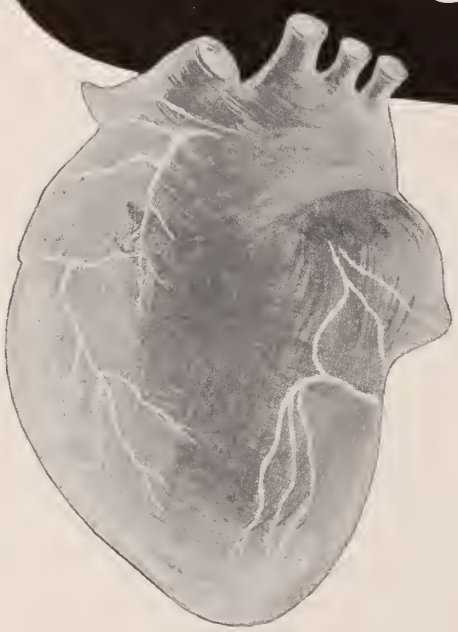

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SAMPLES and LITERATURE ON REQUEST

1. Plotz, N. Y. State Med. Jl. 52:16 (Aug. 15, 1952)
2. Russek and Assoc., 153:3 J.A.M.A. (Sept. 19, 1953)
3. Winsor and Humphreys, Angiology 3:1 (Feb. 1952)
4. Russek and Assoc., Am. Jl. Med. Sciences (Jan. 1955)

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Society Proceedings

Ashland–Bayfield–Iron

When the Ashland–Bayfield–Iron County Medical Society met on August 10 at the Menard Hotel, Ashland, *Dr. Harold Sorensen* of Eau Claire was the guest speaker. He spoke on low back pain, the history and physical examination, and stressed points of differential diagnosis in disc syndromes, osteoarthritis, spondylolisthesis, and Marie-Strümpell disease.

A letter of congratulation was sent to *Dr. C. W. Lockhart* of Mellen on the occasion of his fiftieth wedding anniversary.

Barron–Washburn–Sawyer–Burnett

Fourteen members of the Barron–Washburn–Sawyer–Burnett County Medical Society met on September 13 at the Elks Club, Rice Lake, to hear a talk by *Dr. Samuel T. Sandell* of the Middle River Sanatorium, Hawthorne. His subject was "Diagnosis of Tuberculosis." A film on diagnosis of lung cancer was also shown.

In a business meeting the members determined to notify the county board that the county medical society would approve of publicity of the rabid skunk problem in Barron County and any methods to reduce the skunk population.

A committee was appointed to study the possibility of having a standard insurance form for the counties in the society.

Brown–Kewaunee–Door

Members of the Brown–Kewaunee–Door County Medical Society met on September 8 at Butch Van's, Kewaunee, when they honored *Dr. Robert L. Cowles* of Green Bay. Dr. Cowles, who is retiring after 40 years of practice, was presented with a gift by *Dr. Arthur J. McCarey.*

Dr. R. M. Nesemann, Kewaunee, was program chairman and arranged the meeting.

Dane

Members of the Dane County Medical Society enjoyed a day of golf followed by an evening dinner at the Maple Bluff Country Club, Madison, on September 14. *Drs. A. M. Sonneland* and *Karl Siebecker* were co-chairmen of the event.

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New Booklet Available to Aid Management of Overweight Patients

The 1955 edition of the well-known Knox "Eat-and-Reduce" booklet eliminates calorie counting for your obese patients. This year's edition is based on the use of Food Exchange Lists[1] which have proved so accurate in the dietary management of diabetics. These lists have been adapted to the dietary needs of patients who must lose weight.

The first 18 pages of the new booklet present in simple terms key information on the use of Food Exchanges (referred to in the book as Choices). In the center, double gatefold pages outline color-coded diets of 1200, 1600, and 1800 calories based on the Food Exchanges. Physicians will find these diets easy to revise to meet the special needs of individual patients.

To help patients persevere in their reducing plans, the last 14 pages of the new Knox booklet are devoted to more than six dozen *tested*, low-calorie recipes. Please use the coupon below to obtain copies of the new "Eat-and-Reduce" booklet for your practice.

1. Developed by the U. S. Public Health Service assisted by committees of The American Diabetes Assn., Inc. and The American Dietetic Assn.

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Johnstown, N. Y.

Please send me____copies of the new illustrated Knox "Eat-and-Reduce" booklet based on Food Exchanges.

Kenosha

Forty-two physicians of the Kenosha County Medical Society met at the Elks Club, Kenosha, on September 1 in a business session. Results of recent polio immunizations were discussed, and committee reports were made on local affairs such as short forms for schools, the local blood bank, and better methods for handling emergencies.

Manitowoc

A special meeting of the Manitowoc County Medical Society was held on September 6 at Wellhoefers Sea Grill, Manitowoc, to discuss present problems with poliomyelitis. Recommendations of the members were sought.

Oconto

Dr. L. H. Edelblute of Green Bay was the guest speaker at the meeting of the Oconto County Medical Society on September 20 at the Alamo Club, Stiles. He spoke on "Out-Patient Radiation Therapy."

Seven members of the society were present.

Outagamie

Dr. John Z. Bowers, dean of the University of Wisconsin Medical School, spoke to the members of the Outagamie County Medical Society at their September 15 meeting, held at the Elks Club, Appleton. He discussed "Aspects and Treatment of Arthritis" and also spoke about functions of the medical school. A question-and-answer period followed.

In a business session the members approved holding a rheumatic heart clinic on October 12 and beginning immunization clinics October 10; approved the county Salk vaccine immunization program for a year's trial; and commended the Sisters of St. Elizabeth Hospital, Appleton, for their excellent handling of polio cases during the recent polio epidemic.

Polk

On September 15 members of the Polk County Medical Society were dinner guests of *Dr. J. C. Belshe* of St. Croix Falls at Paradise Lodge, Balsam Lake. Dr. Samuel Hunter of St. Paul, Minnesota, spoke on "Chest Surgery," and a round-table discussion followed.

The poliomyelitis vaccination program was also discussed.

Price–Taylor

The regular quarterly meeting of the Price–Taylor County Medical Society was held on August 20 at the Leahy Clinic, Park Falls. Prior to the meeting a rheumatic fever clinic was held, and the clinic team discussed cases with the members.

Dr. R. H. Wasserburger, consulting cardiologist for the Veterans Administration Hospital, Madison, spoke on "Pediatric Heart Disease" and illustrated his talk with slides. *Dr. Horace K. Tenney, III,*

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Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, October 10
Surgical Anatomy & Clinical Surgery, Two Weeks, October 24
Surgery of Colon & Rectum, One Week, October 17, November 28
General Surgery, One Week, October 17
Gallbladder Surgery, Ten Hours, October 24
Fractures & Traumatic Surgery, Two Weeks, October 17

GYNECOLOGY—Office & Operative Gynecology, Two Weeks, November 28
Vaginal Approach to Pelvic Surgery, One Week, November 7

OBSTETRICS—General & Surgical Obstetrics, Two Weeks, November 7

MEDICINE—Gastroenterology, Two Weeks, October 24
Electrocardiography & Heart Disease, Two-Week Basic Course, October 10
Gastroscopy, Forty-Hour Basic Course, November 7
Dermatology, Two Weeks, October 17

RADIOLOGY—Clinical Course, Two Weeks, by appointment
Clinical Uses of Radioisotopes, Two Weeks, October 10

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Madison pediatrician, spoke on "Acute Rheumatic Fever and Its Treatment."

A business meeting followed the scientific program.

Richland

When members of the Richland County Medical Society met at *Dr. R. E. Housner's* cottage at Orion on September 1, the principal speaker of the evening was *Dr. Robert C. Parkin*, coordinator of postgraduate education at the University of Wisconsin Medical School. He spoke on "The Problem of Small Hospitals in Obtaining Hospital Accreditation. Mr. Roy T. Ragatz, assistant secretary of the State Medical Society, followed as a discussant.

Mr. John LaBissoniere, field secretary of the State Medical Society, spoke to the group on "Impressions Obtained in Manning a Quackery Exhibit."

Sauk

Twenty members of the Sauk County Medical Society met on September 13 at the Warren Hotel, Baraboo, to hear an address by *Dr. Marc Musser*, professor of internal medicine, University of Wisconsin Medical School, Madison. He spoke on "Diagnosis and Treatment in Psychosomatic Medicine."

In a business session, the society elected *Dr. Robert G. Knight* of Reedsburg as president-elect to succeed *Dr. Gibbs W. Zauft* of Prairie du Sac, who is now in military service at Great Lakes, Illinois.

Trempealeau–Jackson–Buffalo

The regular meeting of the Trempealeau–Jackson–Buffalo County Medical Society was held on September 27 at the Alma Hotel, Alma.

Mr. Charles B. Stumpf, former president of the National Association of Health and Accident Underwriters, was the guest speaker. His topic was "Physicians' and Underwriters' Problems in Health and Accident Insurance."

Walworth

Meeting at the Sterlingworth Hotel, Elkhorn, on September 8, the Walworth County Medical Society heard an address by *Dr. Joseph A. Mufson*, of Milwaukee, who spoke on "Treatment of Head Injuries." General discussion followed.

Dr. J. A. Rawlins of Elkhorn was appointed trustee from Walworth County for the Charitable, Educational, and Scientific Foundation of the State Medical Society. *Dr. E. D. Hudson* of Lake Geneva was appointed to represent the county medical society in a meeting of a committee considering the establishment of a full-time health unit.

Wood

A Symposium on Diseases of the Thyroid was presented at the August 18 meeting of the Wood County Medical Society at the Hotel Charles, Marshfield. Participating were *Drs. J. L. Ousley, W. R. Kearney*, and W. P. Quigley, all of Marshfield.

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Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology

Members of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology met on September 10 and 11 at Eagle Waters Resort at Eagle River. *Dr. Francis J. Millen*, assistant professor of neurology at Marquette University School of Medicine and consultant in neurology at the Veterans Hospital, Wood, spoke on "Headaches" and "Multiple Sclerosis and Demyelinating Diseases of the Nervous System." *Dr. R. W. Byrne* of the Department of Radiology, Columbia Hospital, Milwaukee, spoke on "Head and Neck in Roentgen Diagnosis and Treatment."

Golf was played on Saturday morning, September 10; and following the afternoon sessions, a social hour and dinner were scheduled. Entertainment was also provided for wives of the physicians.

Wisconsin Society of Internal Medicine

Dr. Maurice Hardgrove, Milwaukee, was elected president of the Wisconsin Society of Internal Medicine at its organizational meeting held at Monroe on September 17. *Dr. Warren K. Simmons*, Rhinelander, was named vice-president; and *Dr. J. L. Sims*, Madison, was elected secretary-treasurer. Over 75 physicians, representing better than 50 per cent of Wisconsin's certified internists, attended the meeting.

Speakers at the morning session included *Dr. John A. Schindler*, Monroe, who discussed "The Audio-visual Method of Treating Emotionally Induced Illness"; *Dr. W. A. Killins*, Green Bay, whose topic was "Hypertensive Ischemic Ulcer of the Leg;" and *Dr. G. E. Magnin*, Marshfield, who spoke on "Cyclic Neutropenia." *Dr. W. J. Egan*, Milwaukee, served as moderator of a panel on "Philosophy of Medical Practice in the Care of the Citizen"; and *Dr. George A. Hellmuth, Dr. Donald M. Willson*, and Mr. A. H. Luthmers, all of Milwaukee, served as panel members.

The afternoon program consisted of a case report by *Dr. G. W. Carlson*, Appleton, on "Islet Cell Tumor of the Pancreas"; a talk by *Dr. W. K. Simmons*, Rhinelander, on "Adrenomatosis of Brunner's Glands"; and a panel discussion on "Electrocardiography," with *Dr. F. F. Rosenbaum*, Milwaukee, as moderator and *Drs. C. W. Crumpton* and *John Juhl* of Madison and *Dr. Raymond L. Rice* of Milwaukee as panel members.

Dr. Elmer L. Severinghaus, former professor at the University of Wisconsin Medical School and now vice-president in charge of clinical research for Hoffmann–La Roche, Inc., Nutley, New Jersey, was the featured speaker at the dinner held at the Monroe Country Club. His topic was "The Inquiring Physician."

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News Items and Personals

Doctor Heywood at Marshfield Clinic

A recent addition to the staff of the Marshfield Clinic at Marshfield is *Dr. William H. Heywood*, who had been on the psychiatric staff at Winnebago State Hospital for the last two years. Doctor Heywood is a graduate of the University of Oregon Medical School and served his internship at University Hospitals, Madison. He is a Diplomate of the American Board of Psychiatry and Neurology.

Hudson Physician Completes Military Service

On August 1, *Dr. Milton A. Cornwall* returned to the United States following two years of Army service at Landshut, Germany, as a captain in the Medical Corps. After a month's vacation he resumed his practice at the Hudson Clinic, Hudson.

Doctor Burkhardt Resigns as Health Officer

Dr. Edward W. Burkhardt, who served Menomonee Falls as health officer for many years, resigned this position recently. He has practiced medicine for more than 50 years, all except seven months of that time in Menomonee Falls; following graduation from the Homeopathic Medical College of Missouri, St. Louis, in 1896, he practiced at Appleton for seven months.

Doctor Burkhardt will continue his private practice in Menomonee Falls.

Service Clubs Honor Dr. J. F. Bennett

Dr. J. F. Bennett of Burlington, who has practiced in that community for the past 36 years, was honored on August 13 at a joint meeting of the Burlington Kiwanis, Lions, and Rotary clubs held at the Marine Room, Browns Lake. *Dr. L. O. Mastalir*, Burlington, presided at the testimonial ceremonies and stated that Doctor Bennett planned to move to California in the very near future.

Dr. F. F. Newell, who has practiced medicine in Burlington for more than 50 years, presented a gift to Doctor Bennett on behalf of the three service organizations.

Dr. James Boren Returns to Marinette

Dr. James Boren has rejoined the Boren Clinic, Marinette, after completing a residency in surgery at the Mayo Clinic. He graduated from Northwestern University Medical College, Chicago, in 1948.

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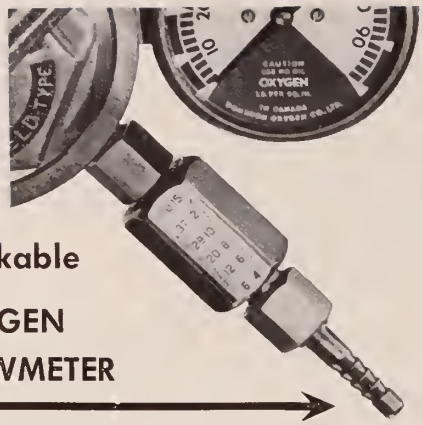

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Doctor Watunya Appointed Coroner

Dr. Michael J. Watunya of La Crosse has been appointed county coroner by Governor Kohler. He succeeds *Dr. George D. Reay,* who recently resigned.

Dr. R. D. Taylor Speaker at Nurses Meet

Dr. R. D. Taylor of the Doege Medical Center, Marshfield, was the guest speaker at the September 22 in-service program for professional graduate nurses at St. Joseph's School of Nursing, Marshfield. His topic was "Serenity in Nursing."

THIRD AND TWELFTH DISTRICTS NEWS

Beloit Clinic Moves to New Building

A staff of 8 physicians and 14 office personnel has moved into the new Beloit Clinic at 1146 Grant Street. This new clinic includes 19 consultation rooms, a laboratory, 4 waiting rooms, 2 x-ray rooms, a soundproof room for hearing tests, a doctors' lounge-library, a personnel lounge, a general office, and a record room.

Physicians associated with the clinic are *Dr. William M. Fitzgerald* and Dr. Robert Chauncey, internal medicine; *Dr. K. L. Carter,* general surgery; *Dr. R. J. Sanderson* and Dr. Joseph Herbert, obstetrics and gynecology; *Drs. Frank Johnson* and *William Freeman,* pediatrics; and *Dr. Allen H. Twyman,* ear, nose, and throat.

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Dr. Edward Purcell Begins Madison Practice

Drs. C. K. Schubert and *C. W. Aageson* of Madison have announced the association of *Dr. Edward F. Purcell* with them in the practice of ophthalmology. Doctor Purcell is a 1949 graduate of Jefferson Medical College, Philadelphia. He served three years as a Navy medical officer. His graduate studies and residency were taken at Receiving Hospital and Kresge Eye Institute, Detroit, Michigan.

Doctor Zauft Enters Military Service

Dr. Gibbs Zauft, who practiced at Prairie du Sac, entered service with the Navy in July and is stationed at Great Lakes, Illinois. *Dr. Milton Trautmann,* with whom he was associated, has announced that Dr. James Trautmann, a graduate of the University of Minnesota Medical School, is now associated with him in general practice.

Doctor Benkendorf Returns from Service

Dr. Charles Benkendorf, who served the past two years with the Navy at Miami, Florida, has received his discharge and is now taking a residency in radiology at Wisconsin General Hospital, Madison. Doctor Benkendorf formerly practiced at Monticello.

Dr. E. S. Gordon Addresses Teachers Group

Dr. E. S. Gordon of Madison addressed the Fall Teachers Convocation at Waukesha on August 5. His address centered around the emotions of children and adults, and slides were used to illustrate his lecture.

Doctors Derus and Rennebohm Associated in Madison

Associated in the new Monona Grove Clinic at 5001 Monona Drive, Madison, are *Dr. Gerald Derus* and *Dr. John Rennebohm.* Both physicians graduated from the University of Wisconsin Medical School in 1952.

Dr. John Huston Laboratory Director

Dr. John H. Huston, who had been studying methods of diagnosing heart disease the last two years under a fellowship from the Wisconsin Heart Association, has been named director of the Marquette University School of Medicine's reorganized cardiopulmonary laboratory at Milwaukee County Emergency Hospital. The laboratory serves as a diagnostic center for heart and lung diseases which can be corrected by surgery and as a center of research and education for young physicians, medical students, and nurses.

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Doctor Huston graduated from Northwestern University Medical School in 1944 and completed training in internal medicine as a resident at Milwaukee County Hospital. His special study in heart conditions was done at the University of Wisconsin Medical School.

Doctor Schindler Receives Award for Book

Dr. John Schindler of Monroe was one of four authors recently awarded the medal of the Christophers, a society dedicated to raise the standards of government, education, literature, entertainment, and labor relations. The award was given for his book, *How to Live 365 Days a Year.*

Dr. Armand Quick Speaks at Fond du Lac

Dr. Armand J. Quick, one of the recognized world authorities on hemorrhagic diseases, and professor of biochemistry at Marquette University, addressed a group of hemophilia sufferers on August 14 at Lakeside Park, Fond du Lac. Attending were sufferers of the disease and their families and other interested persons from Green Bay, Two Rivers, Sheboygan, Fond du Lac, Richland Center, West Allis, Waupun, Lamartine, and Chicago.

Marquette–Jackson Clinic Program Held September 24

The annual Marquette–Jackson Clinic Postgraduate Program was held at the Jackson Clinic, Madison, on September 24. Speakers included *Drs. Robert A. Straughn, Hubert C. Ashman, John H. Flinn, Addie M. Schwittay,* and *John J. Mueller* of the Jackson Clinic staff; Dr. James J. Foster of Marquette University; Dr. Mark W. Garry of the Veterans Administration Hospital, Wood; Dr. John Z. Bowers, dean of the University of Wisconsin Medical School; and *Dr. John S. Hirschboeck,* dean of Marquette University School of Medicine.

Doctor Biason Moves to Illinois

Dr. Perfecto M. Biason, who practiced at Clinton for the last two years, has moved to southern Illinois. He has asked the Medical Society to assist him in obtaining a replacement at Clinton.

SOCIETY RECORDS

New Members

A. E. Schultz, 1300 University Avenue, Madison.

J. B. Durst, 1707 Main Street, La Crosse.

J. W. Kearns, 238 West Wisconsin Avenue, Milwaukee.

Mary A. Hall, 4042 North Wilson Drive, Milwaukee.

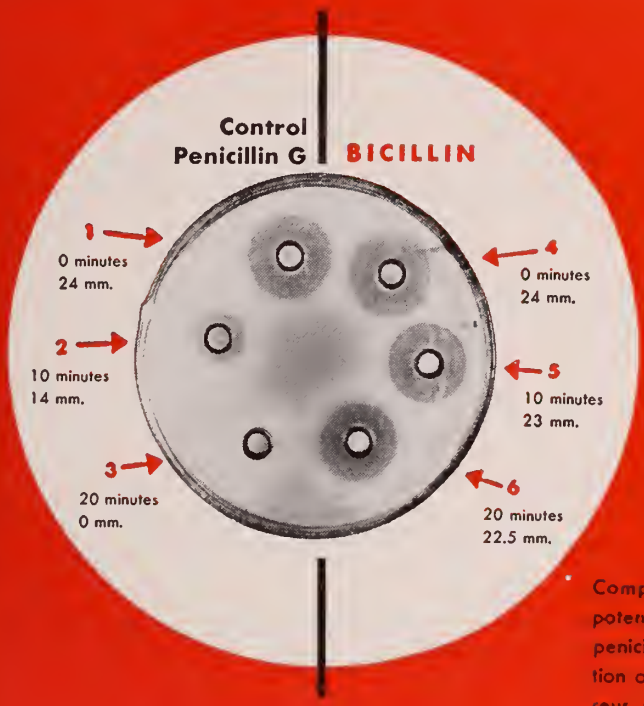
Ruth M. Dalton, 925 Mound Street, Madison.

D. R. Janicek, 110 East Main Street, Madison.

W. H. Ylitalo, 2 West Gorham Street, Madison.

W. R. Kearney, 650 South Central Avenue, Marshfield.

J. L. Ousley, 650 South Central Avenue, Marshfield.



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1. American Medical Association: New and Nonofficial Remedies. J. B. Lippincott Co., Philadelphia, 1954, p. 147.

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Recent results of laboratory and clinical research on the medical attributes of wine have been condensed into a small brochure entitled "Uses of Wine in Medical Practice." A copy is available to you—at no expense—by writing to: Wine Advisory Board, 717 Market Street, San Francisco 3, California.

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Changes of Address

A. J. Boner, Madison, to 1451 Durango Avenue, Los Angeles, California.

L. O. Mastalir, Madison, to Burlington.

R. H. Pfeifer, San Mateo, California, to 1314 S. E. Second Avenue, Fort Lauderdale, Florida.

W. H. Heywood, Winnebago, to 650 South Central Avenue, Marshfield.

Laurie L. Allen, Milwaukee, to 410 Kasota Street, Cincinnati, Ohio.

C. H. Kratchovil,** Madison, to Department of Physiology–Biophysics, School of Aviation Medicine, Randolph Air Force Base, Texas.

L. J. Friend, Beloit, to 407 East Lake View Avenue, Milwaukee.

S. E. Sivertson, Rochester, Minnesota, to 1836 South Avenue, La Crosse.

V. C. Epley,** Fort Miles, Delaware, to 5012 S.U., U. S. Army Infirmary, Fort Sheridan, Illinois.

F. W. Reibold, Superior, to 603 Parkwood, N. E., Grand Rapids, Michigan.

E. F. White, Statesan, to Harlingen State Tuberculosis Hospital, Harlingen, Texas.

R. J. Krill, Milwaukee, to Francis Delafield Hospital, Columbia Presbyterian Medical Center, New York, New York.

J. L. Kinsey,** New London, Connecticut, to Staff Commander, Submarine Squadron 5, % Fleet Postoffice, San Francisco, California.

D. L. Knutson, Milwaukee, to 237A Wisconsin Avenue, Waukesha.

D. A. Cofrin, Oklahoma City, Oklahoma, to 1105 South Jackson Street, Green Bay.

R. A. Hanson,** Montgomery, Alabama, to Route 3, Box 165A, San Antonio, Texas.

P. R. Savino, Denver, Colorado, to 9331 West Wisconsin Avenue, Milwaukee.

J. H Huston, Madison, to 1824 Church Street, Wauwatosa.

Charles Benkendorf, Miami, Florida, to 1300 University Avenue, Madison.

T. P. Froehlke, Columbus, Indiana, to 1008 Curtiss Street, Downers Grove, Illinois.

D. C. Bleil, Indianapolis, Indiana, to 342 North Water Street, Milwaukee.

W. F. Merdinger, Milwaukee, to % City of Hope Medical Center, Duarte, California.

G. W. Zauft,** Prairie du Sac, to Station Hospital, Great Lakes Naval Training Station, Great Lakes, Illinois.

** Military Service.

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DEATHS

Dr. Noel A. Gillespie, 50, a member of the University of Wisconsin Medical School Department of Anesthesia since 1939, died at a Madison hospital on August 21 following a short illness.

Born in London on December 25, 1904, Doctor Gillespie was educated at the Perse School, Cambridge, and at New College, Oxford. He received his medical degree from the University of Wisconsin and joined the University of Wisconsin faculty in 1939. Between 1934 and 1939 he had served on the staffs of several British hospitals.

In late years his special interest was in endotracheal anesthesia and in records and statistics. His volume, *Endotracheal Anaesthesia*, was published in 1941 and again in 1948 and has been regarded as one of the most definitive works ever published in the field. His annual statistical reports, analyzing the work of his department, have served as models for medical departments throughout the country.

Doctor Gillespie had no immediate relatives.

Dr. Charles Stanley Hayman, Boscobel, passed away on August 11 at the age of 83 years.

He was born on February 26, 1872, at Racine, Ohio, and received his medical degree from Rush Medical College, Chicago, in 1895. He began his practice that year by joining his uncle, Dr. L. H. Hayman, at Boscobel.

Doctor Hayman was a member of the Grant County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He had been health officer in Boscobel in the past and was one of three doctors who organized the first city hospital and clinic in that community in 1916. He had served his county society as president and through various committees of that society.

He had been president of the Boscobel State Bank for 25 years and was also active in other civic organizations. Since 1927 he had been a railroad physician.

Over 500 residents of the Boscobel area honored Doctor Hayman on August 17, 1950, in recognition of his 55 years of service to the community. The doctor was presented with a watch and traveling bag, and a reception and dinner were held for him.

He was a member of the Fifty Year Club of the State Medical Society.

Survivors include his widow, Myrtle; a stepdaughter, Mrs. Margaret Patch, Boscobel; a foster son, Ivan Steiner, Chicago; a sister, Mrs. Myrtis Ihle, Buckeye Lake, Ohio; and two brothers, Fred L. of Columbus, Ohio, and Eber of Parkersburg, West Virginia.

Dr. Walter Pierson Tippet, 60 years of age, died at his home in Green Bay on September 12 after an extended illness.

Doctor Tippet was born on November 14, 1894, at Neenah and received his medical degree from the University of Illinois. He interned at West Side Hospital, Chicago, in 1925 and at Milwaukee County Hospital in 1926. After completing a year's residency at Milwaukee County Hospital in 1927, he started his practice at Green Bay.

He served in the Armed Forces during World War I, and was decorated with the Purple Heart by the U. S. government and the croix de guerre by the French government.

Doctor Tippet was a general practitioner and had special interest in obstetrics. He had served as the Wisconsin State Reformatory physician at Green Bay. He had been president of the staff of Bellin Memorial Hospital.

In addition to his medical duties, Doctor Tippet had been president of the Green Bay Y.M.C.A.; and he had served two six-year terms as a trustee of Lawrence College, Appleton.

He was a member of the Brown–Kewaunee–Door County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association and had held the offices of president and secretary of his county society in the past.

Surviving are his widow, Melba; two daughters, Janet, now Mrs. Frederic Goldsmith of Whitefish Bay, and Sylvia, now Mrs. Ray Nelson of Fort Knox, Kentucky; and a brother, Earl J., of Whitefish Bay.

CORRECTION

Our attention has been called to the incorrect printing of the first paragraph of the obituary of Dr. C. P. Arnoldussen which appeared in the September issue of the Journal on page 42. Below is the paragraph as it should have been printed:

> **Dr. Chris P. Arnoldussen**, 44-year-old Fremont physician who was fatally injured in an automobile accident while en route to the hospital at New London, Wisconsin, died on July 15. The accident occurred just after he had delivered a baby in a car in front of his home and was driving behind the car to the hospital.

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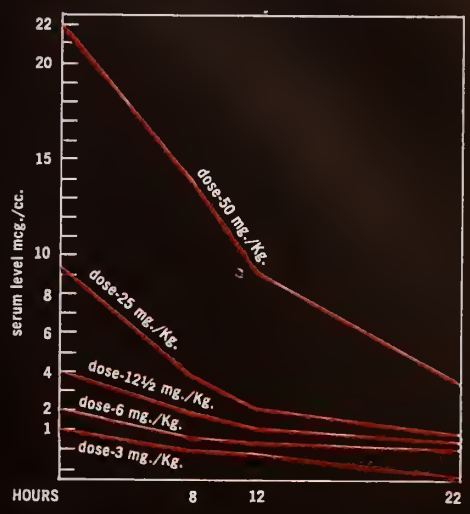

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O'Regan, C., and Schwarzer, S.: J. Pediat. 44:172 (Feb.) 1954.

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Diagnostic X-ray and Laboratory Services Rider

When this rider is in effect, Wisconsin Physicians Service will provide allowances for diagnostic x-ray and laboratory services when performed and billed by a licensed physician and surgeon, to the extent of the charges made by the physician but not exceeding the amounts described in the Schedule of Benefits. The total amount payable during any one "benefit period" shall not exceed the "maximum diagnostic allowance." A "benefit period" is defined to mean the six-month period beginning with the first day that services payable under the rider are rendered by the physician. Benefits are available for each participant under the contract. The allowances cover urinalysis and fluoroscopic examinations where performed as part of a general physical examination rather than as isolated procedures. They also cover dental x-ray examinations necessitated by accidental bodily injury to the jaws or teeth.

The full payment provisions of Blue Shield do not apply to the rider. However, participating physicians will receive direct payment.

Benefits not provided are physical examinations required in connection with the participant's occupation, employment, or purchase of insurance; examinations related to pregnancy or for the determination of pregnancy; and hospital services or charges made by a nursing home, convalescent home, or similar institution.

Specific Diseases Rider

When this rider is in force, Wisconsin Physicians Service will pay, for professional services and other services and supplies, the "customary, usual and reasonable" charges incurred as a result of a "specific disease." The total of all benefits payable under this rider shall not exceed a maximum set for each participant and for each family.

"Specific diseases" are limited to diphtheria, encephalitis, leukemia, poliomyelitis, rabies, scarlet fever, smallpox, spinal meningitis, tetanus, and tularemia. Benefits will be paid for services performed and billed by a licensed physician and surgeon; services of a licensed or registered physical therapist or nurse under the direction of the attending physician; established ambulance service for transportation to and from a hospital; rail or plane transportation by scheduled commercial aircraft under limited circumstances; and drugs and medicines, the purchase or rental of necessary braces and crutches, wheel chairs, or hospital-type beds, and the rental of iron lungs or other mechanical equipment for the treatment of respiratory complications.

The above is a brief description of both riders. The exact conditions of each will be supplied upon request.

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RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by examination by the State Board of Medical Examiners at a meeting in Milwaukee, July 12 to 14, 1955.

Name	*School of Graduation*	*Year*	*Address*
Baldzikowski, Ralph A.	Marquette University	1954	3153 S. 29th, Milwaukee
Bannen, Bernard Richard	Marquette University	1954	Hospital for Mental Diseases, Milwaukee
Barcome, Donald Francis	University of Wisconsin	1954	6129 Deckner, Green Bay
Berghoff, James Raymond	Marquette University	1954	306 E. Jefferson, Fort Wayne, Ind.
Bischel, Jerome Raymond	Marquette University	1954	Milwaukee Children's Hospital, Milwaukee
Bouman, Harry Dan	University of Amsterdam	1933	University Hospitals, Madison
Boyd, Andrew, Jr.	University of Pennsylvania	1954	2200 W. Kilbourn, Milwaukee
Brady, John Jennings	Marquette University	1954	4228 W. Oklahoma, Milwaukee
Brodhun, John Charles	Marquette University	1954	615 S. Walnut, Appleton
Cain, William Joseph	Marquette University	1954	Milwaukee Children's Hospital, Milwaukee
Capps, Robert Truman	University of Wisconsin	1954	1300 University Ave., Madison
Card, William Hays	University of Wisconsin	1954	2857 S. Lenox St., Milwaukee
Cline, Richard Stanley	Marquette University	1954	5455 N. 60th St., Milwaukee
Cohen, Albert M.	Marquette University	1954	V. A. Hospital, Wood
Cooper, Thomas Henry	Marquette University	1954	Atherton Hall, Union Grove
Cordes, John Edwin	Marquette University	1954	3304 N. Oakland, Milwaukee
Cox, Thomas John	Marquette University	1954	2402 N. 67th, Milwaukee
Davis, John Borton	University of Wisconsin	1954	Markesan Medical Center, Markesan
Dhuey, Joseph Norbert	University of Wisconsin	1954	5919 W. Vliet, Milwaukee
Donahue, Lawrence A.	Marquette University	1954	Cleveland Clinic, Cleveland, Ohio
Dugan, Thomas Emerson	Marquette University	1954	2109 N. Buffum, Milwaukee
Dungar, Charles Francis	Marquette University	1954	R. R. 5, West Bend
Dye, Eugene Norman	Northwestern University	1954	Mendota State Hospital, Madison
Ebbe, Shirley Nadine	University of Oregon	1954	Milwaukee County Hospital, Milwaukee
Eid, Charles Harrison	University of Wisconsin	1954	City Hospital of Akron, Akron, Ohio
Erickson, Milo Rodney	University of Wisconsin	1954	2429 Center Ave., Madison
Failor, Harlan John	University of Wisconsin	1954	425 Fourth Ave., S. W., Rochester, Minn.
Feulner, Robert Charles	University of New York	1953	Milwaukee County Hospital, Milwaukee
Fowler, Jesse Ralph	University of Illinois	1954	Waterloo
Franklin, Richard Lee	University of Wisconsin	1954	4073 N. Montreal, Milwaukee
Frantz, Richard George	University of Wisconsin	1954	2200 W. Kilbourn, Milwaukee
Fricano, Salvatore	Marquette University	1954	2229A S. Winchester, Milwaukee
Gallimore, Harriet L.	Creighton University	1943	623 N. 63rd St., Wauwatosa

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Name	*School of Graduation*	*Year*	*Address*
Gass, Howard Irving	University of Wisconsin	1954	2200 W. Kilbourn, Milwaukee
Gay, Brian Cameron	University of Ottawa	1951	Caylor–Nickel Clinic, Bluffton, Ind.
Gelfman, Nelson Alfred	University of Pennsylvania	1954	Mendota State Hospital, Madison
Gimenez, Alonzo Rudolfo	St. Louis University	1954	8700 W. Wisconsin Ave., Milwaukee
Goodman, Richard Stuart	University of Wisconsin	1954	1625 E. Fairmount, Milwaukee
Graziano, Samuel A.	Marquette University	1954	2936 N. Third, Milwaukee
Guhl, James Frederick	Marquette University	1954	3257 S. Delaware, Milwaukee
Halgrimson, Kenneth W.	University of Maryland	1954	422½ Bellinger, Eau Claire
Hammes, David Arthur	University of Wisconsin	1954	207 E. Walnut St., Green Bay
Heidner, Frederick C., II	University of Wisconsin	1954	Lutheran Hospital, La Crosse
Heilman, Richard B.	University of Wisconsin	1943	Endeavor
Hein, William Edward	University of Wisconsin	1954	Monroe Clinic, Monroe
Heinz, Leonard Melvin	University of Wisconsin	1954	1444 Univ. Tr., Apt. 525, Ann Arbor, Mich.
Janssen, William Charles	Marquette University	1954	Columbia Hospital, Milwaukee
Jeffrey, James Stanley	University of Nebraska	1954	120 E. Wisconsin Ave., Kaukauna
Johnson, Rhoda Ellen	University of Wisconsin	1954	3321 N. Maryland, Milwaukee
Karich, Anthony Frank	Marquette University	1954	1506 97th Ave., W. Duluth, Minn.
Keepman, Jay Paul	University of Wisconsin	1954	621 S. Park St., Madison
Keuer, James Robert	Chicago Medical School	1954	1906B West Brown, Milwaukee
Kline, Joyce Claire	University of Wisconsin	1954	162 Proudfit St., Madison
Kmiecik, Joseph Edward	University of Wisconsin	1954	Columbia Hospital, Milwaukee
Koch, Charles Bernard	University of Illinois	1954	New Lisbon
Kristensen, Lowell A.	Yale University	1954	Chetek
Kroncke, George Michael	University of Wisconsin	1954	University Hospitals, Madison
Kubiak, Mary K. King	University of Wisconsin	1954	Winnebago State Hospital, Winnebago
Larson, Duane Lester	University of Wisconsin	1954	University Hospitals, Madison
Lavette, William Michael	Marquette University	1954	5475 N. 60th St., Milwaukee
LeMieux, Gerald Edward	University of Wisconsin	1954	712 N. Ashland, Green Bay
Liechtey, Richard Delmar	Northwestern University	1954	Lake Geneva
Lovett, Myron Nelson	University of Wisconsin	1954	2452 N. 50th, Milwaukee
Makowski, Edgar L.	Marquette University	1954	3150 Raleigh, Apt. 106, St. Louis Park 16, Minn.
Massa, Emil Joseph	Northwestern University	1953	19 E. Monroe, Chicago, Ill.
Matzke, Rudolf William	University of Wisconsin	1954	Mendota State Hospital, Madison
Mehigan, David Michael	Marquette University	1954	4455 N. Oakland, Milwaukee
Miller, David Francis	University of Wisconsin	1954	911 N. Central Ave., Marshfield
Mol, Henry Roger	State University of Iowa	1954	Elkhorn
Murawsky, William V.	Marquette University	1954	3418 N. 23rd St., Milwaukee
Nachman, Allen Elias	University of Nebraska	1954	V. A. Hospital, St. Louis, Mo.

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Newton, Richard Milton	Medical College of Virginia	1954	1300 University Ave., Madison
Nitz, George Karl, Jr.	University of Wisconsin	1954	726 Crooks St., Green Bay
Nora, James Jackson	Yale University	1954	Cambridge
Oberdorfer, Claude Elmer	Marquette University	1954	V. A. Hospital, Wood
Oilschlager, Gerald A.	George Washington University	1953	138 Section, Nekoosa
Olsen, Ralph Norman	University of Wisconsin	1954	University Hospitals, Madison
Otterson, Warren Nels	University of Wisconsin	1954	213 N. Center, Beaver Dam
Pavlic, Robert Stephen	Marquette University	1954	St. Joseph's Hospital, Milwaukee
Petersen, John Robert	University of Wisconsin	1954	2020 E. 93rd St., Cleveland, Ohio
Pezanoski, Edward J.	University of Wisconsin	1954	1912 Grand Ave., Racine
Picus, Charles Louis	University of Wisconsin	1954	2690 Ewald Circle, Detroit, Mich.
Poll, Marvin	University of Wisconsin	1954	Jewish Hospital Association, Cincinnati, Ohio
Rafferty, Hugh Peter	Marquette University	1954	6115 10th Ave., Kenosha
Rainey, Richard William	Marquette University	1954	3940 N. 53rd St., Milwaukee
Ravn, Erling Oscar, Jr.	Marquette University	1954	Madison General Hospital, Madison
Redfern, William Thomas	Marquette University	1954	V. A. Hospital, Wood
Rhodes, John Daniel, Jr.	Meharry Medical College	1954	813 W. North Ave., Milwaukee
Roesler, Marvin John	University of Wisconsin	1954	Columbia Hospital, Milwaukee
Rogers, Richard Joseph	Marquette University	1954	Elkhorn
Rosenberg, Jerry C.	Chicago Medical School	1954	132 Washington St., Wisconsin Dells
Rosenblum, Raymond	Medical College of South Carolina	1954	Milwaukee County Hospital, Milwaukee
Ruehl, Roger LeRoy	Marquette University	1954	8423A W. Lisbon, Milwaukee
Rufflo, Robert Anthony	Marquette University	1954	7769 Third Ave., Kenosha
Rupel, John Walker	University of Texas	1954	St. Mary's Hospital, Milwaukee
Sargeant, Thomas S.	Marquette University	1954	Milwaukee County Hospital, Milwaukee
Scheuermann, Nyal M.	Marquette University	1954	130 Main St., Oshkosh
Schrader, William A., Jr.	University of Wisconsin	1954	636 Jefferson, Oshkosh
Schumacher, Bernhard J.	Marquette University	1954	8700 W. Wisconsin Ave., Milwaukee
Shulkin, Mark Weiss	University of Wisconsin	1954	1021 Woodbine St., Pittsburgh, Penn.
Simenstad, John Otis	Johns Hopkins University	1954	Osceola
Smith, Porter Hulsart	University of Pennsylvania	1953	University Hospitals, Madison
Songe, Robert Abbott	University of Wisconsin	1954	1891 Norwood Dr., Grosse Pointe Woods, Mich.

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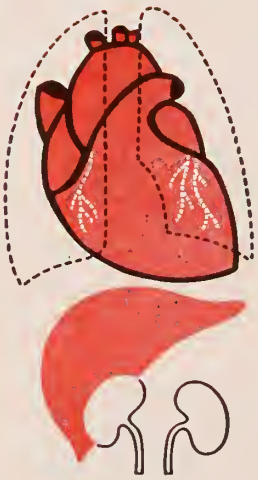

diuresis without depletion of alkaline reserve—avoiding dangers of acid-base imbalance—is characteristic of the organomercurials. In contrast, the diuretic activity of carbonic anhydrase inhibitors, acidifying salts, and the resins depends on production of acidosis.

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BRAND OF CHLORMERODRIN
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88756

Name	School of Graduation	Year	Address
Sorenson, James Maclin	Marquette University	1954	6254 N. Port Washington Rd., Milwaukee
Spitz, Milton Baron	University of Wisconsin	1954	1701 W. Wright St., Milwaukee
Stewart, James Paul	University of Cincinnati	1954	425 Lorch St., Madison
Stockton, Richard W.	University of Wisconsin	1954	Sun Prairie
Stolp, Sherwood Bernard	Marquette University	1954	5427 N. 67th St., Milwaukee
Steussy, Milton Franklin	University of Wisconsin	1954	Hickory St., Platteville
Teplinsky, Jacob Joseph	University of Wisconsin	1954	7500 S. Shore Dr., Chicago, Ill.
Theisen, Charles Edward	Marquette University	1954	103 W. College Ave., Appleton
Thompson, Darel Joseph	Marquette University	1954	Milwaukee County Hospital for Mental Diseases, Milwaukee
Trautmann, James Curtis	University of Minnesota	1954	Prairie Clinic, Prairie du Sac
Urban, Frank Henry	University of Wisconsin	1954	% L. F. Thurwachter, Lookout Dr., Waukesha
Valaske, Martin John	Marquette University	1954	2814 79th St., Kenosha
Vrtilek, Mojmir Rudolf	University of Zurich	1953	2200 W. Kilbourn, Milwaukee
Wainscott, Paul Edgar	Marquette University	1954	138 Main St., Menasha
Ward, Vernon Graves	University of Nebraska	1954	1300 University Ave., Madison
Weinstein, Joseph David	University of Wisconsin	1954	5201 W. Center, Milwaukee
Whereatt, Richard R.	Marquette University	1954	4643 W. Congress, Milwaukee
Wisniewski, John Henry	Marquette University	1954	3857A N. 38th St., Milwaukee
Woloschek, Walter J.	Marquette University	1954	6445 W. Birch, Milwaukee
Wood, Donald Lintz	University of Wisconsin	1954	Elm Grove

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Milwaukee, July 12 to 14, 1955.

Name	School of Graduation	Year	Address
Barnes, Richard Oliver	University of Illinois	1944	1545 S. Layton Blvd., Milwaukee
Boyd, Douglas, Jr.	Harvard University	1922	999 Wade St., Highland Park, Ill.
Bradley, Matthew Henry	Ohio State University	1951	V. A. Hospital, Milwaukee
Brooks, James Webster	Medical College of Virginia	1946	Wisconsin General Hospital, Madison
Chancey, Robert Lee	Emory University	1945	Beloit Clinic, Beloit
Coye, Robert Dudley	University of Rochester	1952	University Hospitals, Madison
Cutshall, Roger Ackard	University of Nebraska	1948	Grantsburg
Epp, Milferd John	Washington University	1950	Pippin Clinic, Richland Center
Gambino, Salvatore R.	University of Rochester	1952	2926 S. 51st St., Milwaukee
Garrie, Sander	University of Illinois	1952	Milwaukee County Hospital, Milwaukee
Gundersen, Adolf L.	Harvard Medical	1949	Gundersen Clinic, La Crosse
Haskell, Jack George	University Medical School, Louisville, Ky.	1948	1355 Division St., Green Bay

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Name	*School of Graduation*	*Year*	*Address*
Healy, John Russell	Jefferson Medical	1949	110 E. Main St., Madison
Hughes, Lewis Edwin	University of California	1953	314 E. Grand Ave., Eau Claire
Kemp, Gordon Blair	Hahnemann Medical	1949	1714 E. Capitol Dr., Milwaukee
Lagen, Mansfield Sullivan	University of Iowa	1943	Community Hospital, Lancaster
Lanier, Andrew Stephens	Washington University	1946	Kewaunee
Lanier, Patricia Anne F.	Washington University	1946	Kewaunee
Leppink, Harold Bernard	Wayne University	1949	Milwaukee County Hospital, Milwaukee
Marrone, Patrick Henry	University of Minnesota	1950	2221 E. 2nd St., Duluth, Minn.
Milliken, Lyle David, Jr.	University of Nebraska	1947	625 57th St., Kenosha
Onderak, Edward Pat.	Marquette University	1953	417 Liberty St., Beloit
Osborne, John Vincent	University of Illinois	1947	414 Holly Ave., Elmhurst, Ill.
Palow, Alvin Arthur	Chicago Medical School	1941	N. 12th & Vliet St., Milwaukee
Pinkus, Walter Howard	University of Illinois	1947	610 Sixth St., Racine
Pittelkow, Robert B.	Marquette University	1952	514 16th St., N. W., Rochester, Minn.
Price, Donald Oswald	Albany Medical	1951	1922 University Ave., Madison
Robison, Arnold Edgar	University of Nebraska	1948	University Hospitals, Madison
Senseny, Eugene Foster	Indiana University	1950	Milwaukee County Hospital, Milwaukee
Strakosch, Ernest A.	University of Minnesota	1942	46 Washington Blvd., Oshkosh
Teasley, Jack Lamkin	Duke University	1947	324 E. Wisconsin, Milwaukee
Tybring, Gilbert Benson	University of Buffalo	1945	Mendota State Hospital, Madison
Vogt, George Henry	Cornell Medical	1948	Wisconsin General Hospital, Madison
Wegner, Marwood Emery	University of Minnesota	1953	St. Croix Falls
Zell, John Richard	University of Minnesota	1950	818 W. Kilbourn Ave., Milwaukee
Zimmer, Roy William, Jr.	University of Wisconsin	1953	Box 23, Green Bay

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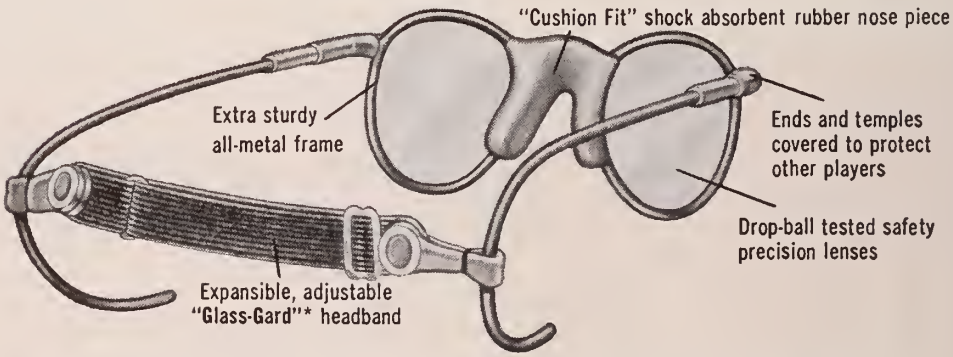

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. . . . THE PRESIDENT'S PAGE . . . .

THE welcome sign now officially hangs at the entrance to 330 East Lakeside Street in Madison, the home of the State Medical Society of Wisconsin. Because it is *our* home, I want to invite every member of our Society to visit there during the coming months. Take your wives and families. Take your friends, too, so that they may see the headquarters of the organization about which they probably hear so much but know so little. You, as well as they, may be amazed not only at the fine structure which has been built on Lake Monona's shore but at the variety and volume of activity that is undertaken there in the interest of both the physician and the public.

The dedication on October 15 was a memorable occasion, disappointing only in that every physician in the state could not be a witness and participant. Those who did attend—and attendance was wholly limited by physical facilities—were the Councilors, officers, delegates and alternates, past-presidents, members of the Commission on Prepaid Plans, and a few special guests. While they were your representatives at the dedication ceremony, you can come to appreciate the great step our Society has taken only by a personal visit. When you do go, plan to spend at least half an hour touring the building. Let the staff know you are coming if you can, especially on a week end. If there's no one about—which is unusual—call one of these: Mr. Crownhart, CE 3–5295; Mr. Ragatz, CE 3–1755; Mr. White, CE 3–9369; or Mr. Doran, CE 3–2362.

By way of a review and perhaps to whet your appetite for a visit, the major part of this issue of *The Wisconsin Medical Journal* is devoted to the dedication. On the following pages, you will find a transcript of the ceremony itself, a reproduction of the dedication program, the major addresses, and a pictorial account of the dedication and the opening of the building.

May I emphasize again, this is more than a headquarters. It is our home. In that spirit it was created to serve you. In that spirit you should use it. I invite and urge you to spend some time there soon.

Ervin L. Bernhart M. D.

THE NEW HOME OF THE

Unusual angle photograph emphasizes modern outlines of State Medical Society building. This reveals east end of office with dining room on ground floor and Council room on second floor.

Lake side of building is banked with windows. Dining room and claims department face the lake on ground floor, while Council room and private offices occupy top area. The building is 160 feet long.

Wisconsin Physicians Service claims are processed in the Blue Shield office shown here. Claims for the Veterans Medical Service Agency are also handled here.

STATE MEDICAL SOCIETY

Aerial view of Society home (foreground) looking north across Lake Monona. The "crow-flight" distance from the Society to the Capitol is approximately one and a half miles.

Entrance to the Society offices faces East Lakeside Street. Parking area in front will accommodate 90 to 100 automobiles.

Visitors get their first impressions of the building in the attractive lobby and reception desk area. Two small interview rooms off the lobby are used to receive those who do not need to visit private offices.

All Members

and their wives are cordially invited

to visit

the new home of

The State Medical Society of Wisconsin

at their earliest convenience

The building is
located on the south shore of Lake Monona at
330 East Lakeside Street, Madison.

Its regular office hours are from 8:00 a.m. to 4:45 p.m.
Although the building is usually staffed well beyond these hours,
advance notice will be appreciated if a visit is
planned for a week end.

The State Medical Society of Wisconsin

in the beginning....

Lest the volume of the Minutes of this Society immediately preceding this should be lost or destroyed, the following facts concerning it are here recorded.

The first entry made therein was the "Law of the State of Wisconsin for organizing Medical Societies, first enacted A.D. 1841, concerning County and State Medical Societies, with the alterations and amendments of that law.

Following this were minority and majority reports from a committee to whom the laws of the State for regulating the practice of medicine had been referred, the former signed by Thomas Spencer, the latter by Geo. D. Wilber, C. B. Chapman, C. H. Duck, Jas. P. Whitney and Francis Heubschmann.

Two drafts of Bills for Legalizing the Study of Anatomical Science came next, and the minutes proper of the Society then began the first meeting recorded having been held Jan. 12th, 1847, at the Capitol in Madison, Dr. Mason C. Darling, of Fond du Lac, presiding and Dr. Henry Clark of Walworth acting as Secretary pro tempore.

The sessions of the Society were interrupted from 1861 to 1867 on July 23rd. of which latter year a special meeting was called by Dr. H. A. Youmans, Vice President, at the city of Janesville. At this meeting Drs. J. B. Dousman, H. Van Dusen, J. J. Brown, John Farill, J. Mitchell, W. H. Borden, H. A. Youmans, H. P. Strong & L. J. Barrows were present, and Dr. H. P. Strong was elected Secretary to fill the vacancy occasioned by the death of Dr. C. G. Pease.

The next regular meeting was held at Madison Jan. 29, 1868. when it was resolved that the Society should meet annually on the second Wednesday of June at such place as should be determined by a majority of the members present at any annual meeting, and the city of Madison was designated as the point where the next meeting should be held.

From the date of this session the record is consecutive, and the minutes of the last session entered in the volume [illegible] 1881

the record continues....

THE SUCCESS of any organization can be measured by its attainments.

Since 1881, the date last mentioned in the Society ledger of that year pictured on the opposite page, Wisconsin's physicians were instrumental in the following steps of progress:

1883—The beginning of tuberculosis control in Wisconsin came with the Society's recommendation to the Board of Health that it separate infected members of the family.

1886—The Society urged the Regents of the University of Wisconsin to establish a pre-medical course.

1896—The Society initiated legislation to prevent blindness in infants.

1897—After 28 years of constant effort, the legislature answered the Society's plea for a State Board of Medical Examiners.

1903—The Society initiated a movement for establishment of tuberculosis sanatoria.

1904—A colony for epileptics was sought.

The Society opened a campaign of public education on tuberculosis.

1915—A hospital for inebriates proposal was promptly chloroformed in committee, the Society's Committee on Public Policy and legislation reported.

1916—Legislature authorized postgraduate medical educational program at University of Wisconsin.

First Committee on Social Insurance appointed by Society president.

1917—House of Delegates pledged support of tuberculosis control measures, postgraduate medical education and right to use dissection in anatomy.

1919—Society efforts of many years bore fruit when endowment of $1,000,000 created for Marquette University Medical School.

1920—Legislature asked to require internship for licensure in Wisconsin.

1925—Society delegate proposed creation of Council on Physical Therapy in AMA.

Society secured passage of the nation's first basic science law.

1932—Society favored broadened choice of physician under Workman's Compensation Insurance.

1933—Poor relief laws modernized by SMS labors.

1934—Fight continued for improved care and treatment of epileptic cases.

1935—State Medical Grievance Committee established by law at request of Society.

1936-37—Society assisted Governor's Citizens' Committee on survey on health and welfare conditions.

1937—More than 100,000 persons visited Society's Hall of Health in Milwaukee.

1937-38—Society authorized and conducted broad studies in fields of health service, sickness care and voluntary systems of hospital insurance.

1938-41—Society experimented in voluntary sickness insurance plans in Superior, Milwaukee and Rock County.

1941—The Society observed its first 100 years.

1942—Procurement and assignment program created to provide physicians for armed forces during World War II.

1943—Society developed an experimental program.

1944—Emergency medical service for civil defense proved successful.

Society initiated plan for postwar years and interviews in Washington and New York, stressing public health programs, manpower needs, education of physicians, public relations, and health insurance.

1945—Society expanded activities in field of health and welfare, care of veterans and insurance.

Wisconsin Medical Journal announced Medical Forum for views on medical economics.

The Society organized The Wisconsin Plan, a prepayment insurance program with Society endorsement sold through private insurance carriers.

1946—The Society created the Wisconsin Physicians' Service and authorized its financing. Also organized was the Veterans' Medical Service Agency of the Society to carry out the home-town care program for veterans with service-connected disabilities.

1947—The Society and the Wisconsin Association of Cooperatives developed agreement and fostered passage of a law authorizing establishment of lay-sponsored and controlled health insurance programs.

1948—Society moved into headquarters on 704 East Gorham Street in Madison.

Society cooperated in organizing of the Wisconsin Public Health Council.

Society directed efforts to secure more adequate care for the aged.

1950—First Wisconsin School Health Conference.

1952—Society initiated a series of conferences with radio and newsmen to bring about improved relationships.

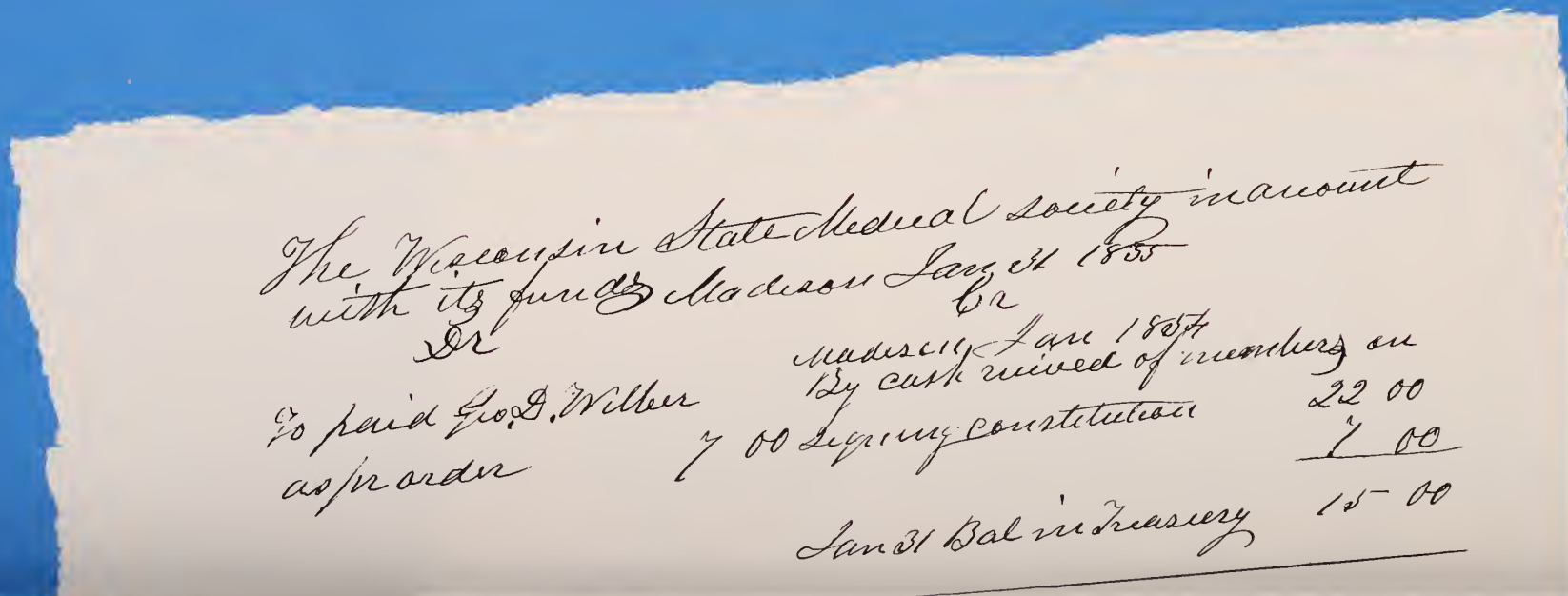
1953—Society proposal for complete modernization of the Medical Practice Act approved by the legislature.

1954—Major Medical Expense Insurance program developed by Wisconsin Physicians' Service.

1955—Society proposed revisions of commitment laws adopted by legislature. Society also proposed medical examiner system for Wisconsin.

October 15, 1955—Dedication of State Medical Society building.

The first known statement of the finances of the State Medical Society of Wisconsin, 1855. (below)



The Wisconsin State Medical Society in account with its funds Madison Jan 31 1855

Dr

To paid Geo. D. Wilber as per order 7 00

Cr

Madison Jan 1854

By cash received of members on signing constitution 22 00

7 00

Jan 31 Bal in Treasury 15 00

Officers OF SOCIETY

President
ERVIN L. BERNHART, MILWAUKEE

President-Elect
L. O. SIMENSTAD, OSCEOLA

Speaker
J. W. FONS, MILWAUKEE

Vice-Speaker
H. J. KIEF, FOND DU LAC

Secretary
C. H. CROWNHART, MADISON

Treasurer
F. L. WESTON, MADISON

Assistant Treasurer
H. KENT TENNEY, MADISON

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J. M. Bell, Marinette
E. L. Bernhart, Milwaukee
G. W. Carlson, Appleton
J. P. Conway, Milwaukee
W. P. Curran, Antigo
E. M. Dessloch, Prairie du Chien
V. E. Ekblad, Superior
J. C. Fox, La Crosse
S. E. Gavin, Fond du Lac, *Chairman Emeritus*
R. E. Galasinski, Milwaukee
R. E. Garrison, Wisconsin Rapids
A. H. Heidner, West Bend
N. A. Hill, Madison
W. D. James, Oconomowoc
H. E. Kasten, Beloit
L. H. Lokvam, Kenosha
N. J. Wegmann, Milwaukee

Arthur J. McCarey, Green Bay
Past-President

Delegates to the American Medical Association

S. E. Gavin, Fond du Lac
D. H. Witte, Milwaukee
W. D. Stovall, Madison
J. C. Griffith, Milwaukee

Alternate Delegates

L. O. Simenstad, Osceola
G. E. Forkin, Menasha
E. L. Bernhart, Milwaukee
R. E. Galasinski, Milwaukee

THE STATE MEDICAL SOCIETY OF WISCONSIN

DEDICATION CEREMONY

3:00 P.M., SATURDAY, OCTOBER 15 **1955**

PRESIDING
W. D. Stovall, M.D., Madison, Past-President, State Medical Society

INVOCATION
E. J. O'Donnell, S.J., Milwaukee, President, Marquette University

REMARKS OF THE PRESIDENT
Ervin L. Bernhart, M.D., Milwaukee; escorted by L. O. Simenstad, M.D., Osceola, President-Elect

APPRECIATORY REMARKS
Vernon W. Thomson, Attorney General, State of Wisconsin; escorted by H. Kent Tenney, M.D., Madison, Member, Building Committee

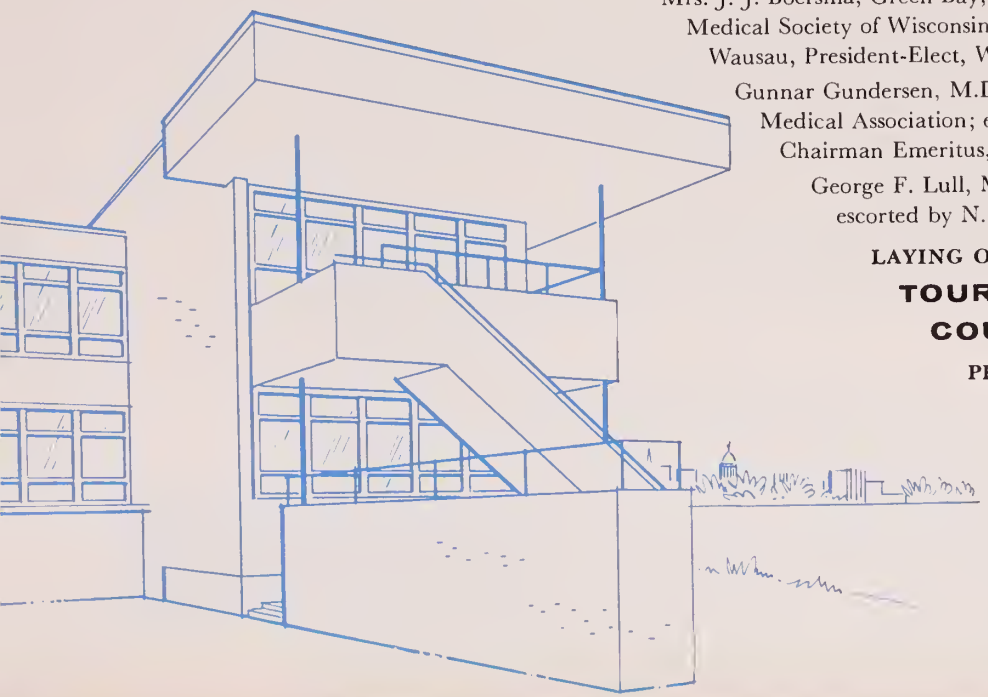
Elmer Hess, M.D., President, American Medical Association; escorted by E. M. Dessloch, M.D., Prairie du Chien, Chairman, Building Committee

Mrs. J. J. Boersma, Green Bay, President. Woman's Auxiliary of the State Medical Society of Wisconsin; escorted by Mrs. H. W. Christensen, Wausau, President-Elect, Woman's Auxiliary

Gunnar Gundersen, M.D., La Crosse, Chairman, Board of Trustees, American Medical Association; escorted by S. E. Gavin, M.D., Fond du Lac, Chairman Emeritus, Council of the State Medical Society

George F. Lull, M.D., Chicago, Secretary, American Medical Association, escorted by N. A. Hill, M.D., Madison, Member, Building Committee

LAYING OF CORNERSTONE



TOURS OF THE SOCIETY BUILDING 4:00 P.M.

COUNCIL DINNER 5:30 P.M.

PRESIDING
R. G. Arveson, M.D., Frederic, Chairman, Council, State Medical Society

ADDRESS
"The Heart of Medicine"
Lowry H. McDaniel, M.D., Tyronza, Arkansas, Chairman, Section on General Practice, American Medical Association

History OF THE SITE OF THE STATE MEDICAL SOCIETY OF WISCONSIN

THERE is scarcely an inch of lake shore line in the Tychopera (the Indian name for the lake region with which nature has blessed the Madison area) but has an interesting historical background. This is particularly true of that stretch along the south shore of Lake Monona beginning from the Milwaukee and St. Paul Railroad tracks on the west and extending eastward to the tip of Turville Point as it juts out into the lake.

The State Medical Society of Wisconsin, formerly located at 704 East Gorham Street on the south shore of Lake Mendota in what was formerly the Collins home, elected to build its permanent quarters on a section of this three-quarter mile of lake frontage on Lake Monona.

In the beginning, of course, there was the Mound Builder whose enduring earthworks dot the Madison area and whose advent, according to some authorities, goes back some 1500 years, when what is known as the Hopewell tribe of that interesting people made its way up the Mississippi and Rock River valleys. Centuries later, some 400 years ago, came the American Indian whom the white pioneer knew as the Winnebago. Recorded history, as it affects the Madison area, began about 1836 and it was in that year that Charles H. Larkin secured a United States Patent (so it was called) to a considerable tract of land of which the site of the State Medical Society of Wisconsin is a part.

The abstract of title to the Medical Society lot bristles with numerous transfers of ownership involving such names as Larkin and wife to Jesse Rhodes and wife (this is the first), in 1837, John M. Rhodes, 1847, Leonard J. Farwell, Delaplaine, Burdick, Thomas S. Lawrence, Charles Doty and Martin Webster (to mention a few) up to 1865. These are mostly early Madison realtors—specu-

Historian, writer, voice teacher, singer, animal lover, outdoorsman—all these apply to Mr. Baas, who wrote the accompanying history of the Society site. He was the son of Madison pioneers. His father, Stephen, was one of the city's first operators of a boat livery. Near threescore and ten, Mr. Baas has traveled widely.

lators would be a better name—who appear in most area title abstracts.

In 1878 James D. Butler's name appears, L. S. Hanks in 1884, W. C. Engel and Edward Lawrence in 1885, and Samuel A. Harper in 1889. That same year came other names famous to old timers—Arthur L. Sanborn and Robert G. Siebecker—and the first mention of The Lake City Gun Club and the Monona Lake Assembly Grounds.

The Gun Club had its target grounds just to the west of Murphy's (now Wingra) Creek. Its property extended west to where the higher land upon which the State Medical Society has built its home begins. The Gun Club land was low and sandy and bare of trees.

Just to the east of the then-called Murphy's Creek was a venture which by some fatality seems to foreshadow and tie in with the new home of the State Medical Society of Wisconsin. Incredible as it may seem, there was erected in the early 1850's on the very spot later occupied by the Monona Lake Assembly Grounds Auditorium a pretentious building "92 feet in length by 40 in width, four stories in height above the basement containing 60 apartments. The dining room and parlor are each forty feet by twenty, with high ceilings. There are to be piazzas on the first and

A view of Madison from the "Water Cure" in 1855 (below). —Courtesy, State Historical Society.

second stories." This is a quotation from Wm. N. Seymour's Madison Directory and Business Adviser, published by Atwood and Rublee, Printers, in 1855. Mr. Seymour goes on to describe what for its day must have been an elaborate establishment called The Lakeside Water Cure, "to be ready for the admission of patients on the first day of June of the present year, 1855." There were pleasure walks, riding paths, boat liveries, a gymnasium, baths—in a word everything that could be found in a well-equipped spa, native or foreign. The water used in the "Cure" or hydropathic treatment came from the nearby stream fed partially by springs. We know the stream today as Wingra Creek.

The establishment with its 50 acres of land fronting on the lake was owned by Messrs. Geo. P. Delaplaine, Elisha Burdick, L. J. Farwell, and J. E. Gross, M. D., director of the medical department. Terms for board and treatment were "$10 to $12 per week, according to rooms occupied!"

Tradition has it that the Lakeside Water Cure did not pay. After a few years of precarious existence, it burned to the ground. But it is a strange coincidence that 100 years after its completion the State Medical Society of Wisconsin should open the doors of its new home a little more than a stone's throw to the west.

Shortly after the demise of the Lakeside Water Cure, the Monona Lake Assembly Grounds were developed on the same site. They lay to the east of Wingra Creek and stretched all the way to the Turville property and were among the most famous of the Chatauqua institutions of their day. For two weeks each summer, the grounds were a tented city to which thousands flocked from far and wide to enjoy the fun of camping out and of listening to programs of high class educational and entertainment value given in the great auditorium that crowned the hill at the southern end of the grounds. The greatest singers, actors, musicians, bands, preachers and politicians appeared on these programs, which included Sam Jones and Talmadge, pulpit orators; Genevra Johnston Bishop, the greatest concert soprano of her day; the first moving pictures to be shown in Madison, one of which showed President McKinley giving an address; Creatore's Band; The French Marine Band; Robert M. LaFollette, Sr.; and William Jennings Bryan. More than 6000 people—some old timers will place the figure much higher—

attended the Bryan speech. A launch had carried him to the Grounds from the city shore. His stately figure clad in black Prince Albert coat, black string bow tie, white "boiled" shirt and crowned with a wide brimmed, black felt hat made him a striking presence. His head was leonine with a mane of hair that fell to his shoulders. His voice was powerful yet singularly sweet and appealing. He had a magnetic personality and was justly considered the greatest orator of his day.

Transportation to the Assembly Grounds was by horse-drawn buses, by train on the St. Paul (now Milwaukee Railroad) and by steamboats. The latter ran from Askew Brothers Angleworm Station at the foot of South Carroll Street and also from the Baas boat livery and steamboat line at the foot of South Hancock Street. Father always moved twelve or fifteen rowboats on a huge barge over to the Assembly while it was in session. This endured until 1906. In due course of time, the city of Madison acquired the Assembly Grounds. It is now called Olin Park in memory of John M. Olin, keen lawyer and public benefactor.

Turn now for a moment to the history of a sizeable piece of land to the west of the State Medical Society building; this is particularly interesting because it ties in, in a general way, with things relating to medical service.

The lot in question was acquired shortly before the turn of the century by the Wisconsin Conference of Seventh Day Adventists. By the year 1900, they had completed a combination sanitarium and hospital modeled after the Battle Creek (Michigan) plan. It operated under a lay board which in turn was governed by the Conference. Dr. W. T. Lindsay began a connection with this institution in 1905 and stayed for three years. Dr. C. P. Farnsworth was the original medical supervisor for the sanitarium. A Mr. Don Bramhall was the original business manager. In 1907 P. L. Larson took Mr. Bramhall's place and remained in the capacity until 1921. The sanitarium closed its doors in 1922.

Doctor Lindsay returned as medical supervisor in 1912 and remained until 1919. He was followed by Dr. Robert S. Ingersoll who carried on until the place closed.

The sanitarium was an imposing three-story structure of frame, ample in size, with roomy verandas running around three sides. It was well patronized in its heyday. Its management purchased a steamboat which made four regular trips

daily to and from the city shore.

After the place closed, a wrecking crew from Chicago was engaged to tear it down. No attempt was made to rebuild.

And now after this somewhat lengthy digression, let us return to the site of the new building which houses the State Medical Society of Wisconsin. It was left with the appearance in the abstract of title of several names prominent in their day and still well remembered by old time Madisonians: Samuel A. Harper, Arthur L. Sanborn and Robert (Judge) Siebecker. Somewhere in the late 1880's or early 90's, a summer cottage made its appearance; and the first reference to "The Cottage Property" occurs in a will of Samuel Harper's in which he gives it to his mother if she survives him. The description is partly as follows: "starts at the north west corner of the Lake City Gun Club—going along Lake Monona 400 feet, then south parallel to the Gun Club 200 feet," etc., to the road. Reference is also made to the "frame cottage"—the same building referred to as "The Cottage Property."

An interesting sidelight: The cottage mentioned above was known as the LaFollette-Siebecker cottage; this cottage was used quite a while as a church school by the Seventh Day Adventists. It is reported to have been used as a hunting cabin and retreat by the LaFollettes and Siebeckers for a time. According to Doctor Lindsay, the cottage occupied the same site now taken by the new structure which houses the State Medical Society of Wisconsin.

In 1904 there is a transaction involving Arthur L. Sanborn and wife to Josephine L. Siebecker and Cornelius A. Harper, M. D. Doctor Harper was state health officer for nearly 40 years. In 1930 Lee L. Siebecker, his wife, Helen, J. C. Harper, Karl L. Siebecker, Robert Siebecker and wife appear. In 1931 Jefferson Crawford Harper, widower, Caroline A., Cornelius A., Elizabeth B. and Mildred L. Harper deeded the property to "The Medical Missionary and Benevolent Association of Wisconsin"; and then this organization gave a warranty deed for the property back to these people—October 25, 1931.

There follow any number of legal ins and outs concerning this or that possible heir or person. In 1953 there is a warranty deed from Margaret Harper Hyland and Louise Schumann, tenants in common, to the State Medical Society of Wisconsin, recorded February 24, 1953.

Address of Elmer Hess, M. D.

President, American Medical Association*

Introduction by Dr. Gunnar Gundersen, La Crosse, chairman of the Board of Trustees, American Medical Association:

Of course Dr. Elmer Hess needs no introduction to this audience because he has been a man who has been prominent in the affairs of medicine in this country for, well, since he played football at the University of Pennsylvania back about 1910, and before the Olympic games in Stockholm in 1912. Elmer is a urologist by profession. He has really made a name for himself in the affairs of American medicine, for in addition to his chosen field of urology, where he was president of the American Urological Association a few years ago, he has been a wheel horse in the affairs of the American Medical Association, having been a member of the Council on Medical Service, that council in the family of the A.M.A. which really does a great deal of spade work and chore work. Elmer has been on that council and, I believe, on every committee of that council in working up to the position he now occupies. It is a distinct honor and real pleasure to present to you the president of the American Medical Association, Dr. Elmer Hess of Erie, Pennsylvania.

Doctor Hess: Chairman of the Council, Gunnar Gundersen, ladies and gentlemen:

I FEEL very highly honored to be invited to be with you on the opening of this building, a truly crowning achievement. It is a great achievement for any state medical society to have its own home; it is an achievement to have it in the capital of the state where all of the legislative activities take place; it is nice to have it here where some of your most well-informed leaders can go to the state capitol and advise the legislators what should and should not be done as far as the health of this state is concerned. I have long pleaded that the A.M.A. have some of its best leaders in Washington. I am convinced that medical research will never stop; we can always find those who are willing to work in a laboratory, who are willing to spend hours and hours experimenting to improve the infor-

* Presented before a joint dinner of the Council and Commission on Prepaid Plans of the State Medical Society, Friday, October 14, 1955, in preliminaries to the dedication ceremonies, R. G. Arveson, M. D., presiding.

mation which we have as clinicians so that we may practice better medicine for those who are ill. So I am not at all disturbed about the future of scientific medicine; but I am terribly disturbed about the mechanics of medical practice. We have seen a great many threats; we have seen medical practice controlled and guided into certain channels which we know and believe to be wrong. I am convinced that our most well-informed leaders have to be near the legislative halls of our states and of our country, for only by giving to the legislator the best advice that we have from a medical point of view can we be assured that the private practice of medicine will continue in this country.

Traffic Accident Problem

We have many problems to face. And I would like to just briefly review one, two, or three of those very serious problems with you this evening in this, your new home. In my opinion, one of the problems which is so important is something which you and I do not really believe to be a medical problem at all, yet to me it is the most serious of all our problems. That is the murder and the crippling that takes place on the highways of America. We kill and maim more people in traffic accidents in the United States of America than any one disease kills or cripples in any given year. That is hard to believe, but all you have to do is look at the record. There are three things we can do about it.

One, we can be the leaders in demanding of manufacturers that every possible safety device be incorporated from an engineering standpoint in the cars sold to the American people so that, in event of an accident, the accident may be minimized instead of exaggerated.

Two, we can demand of our legislators and of our police that the laws be enforced without fear or favor. I am not so much afraid of the fast, safe driver as I am of the slow driver who drives 30 miles an hour in a 50-mile-an-hour speed zone on a two-lane highway.

Three, we must always remember that when we sit down behind the wheel of one of these modern automobiles, we ourselves become potential murderers. We don't realize that we may be responsible for many of these accidents. I would like to see the American medical profession come out with a slogan: Horse sense instead of horsepower on the part of the manufacturer and the driver. In my opinion there should be laws passed and enforced that only those people who are mentally and physically capable be permitted to drive these potential killing vehicles.

Mental Illness

I think we have another very serious and great problem facing American medicine today; that is, the problem of the mentally ill. A man or a woman cannot be physically ill without also being mentally ill. It is impossible to be sick and not be worried; it is impossible to be sick and not be afraid. We sometimes, I think, forget that people have fear. The vast majority of those whom we put in our mental institutions could be saved and returned to productive, satisfactory lives if we had the facilities and the manpower to properly care for them when they do become mentally ill. I would like to see every voluntary hospital in America set aside a certain number of rooms to take care of those with acute mental disturbance until the physicians caring for them are completely assured in their own minds that these people need further mental observation in a state or a national mental institution. I am satisfied that 50 per cent of our people who are mentally disturbed have become so because of the stresses and strains of the modern, speedy life of ours, and that with a little care and consideration most of them could be returned to useful, productive lives.

Medical Ethics

I would like to speak to you for a moment about medical ethics. There is only one fundamental principle in medical ethics and our Principles of Medical Ethics, and that is that physicians take care of sick folks. All the rest of our principles are nothing but rules for our guidance and our conduct with each other and with the public, set up so that we may give to that public the best medical care possible. When we make money an objective in the practice of medicine, we cease to be physicians and, in my book, become simply brutal racketeers. I have become firmly convinced as I have traveled over this great country of ours now for over a year and a half as your emissary that the vast majority

of medical men are decent, clean, and fine. I think few of them put money above service. I would say that the men who consider money as the primary objective of the practice of medicine are extremely short-sighted —why not rather think in terms of giving service to those who depend so much upon us? It isn't the money we leave behind us, it's the reputation. The only things that live and live forever are the things of the spirit, the things that you do and the things that I do without any thought of material or personal reward; and very often a "thank you" from a mother or a father is very much more valuable than any fee that they could give us.

I would like to feel that this profession that we represent is bigger than any other profession on the face of the earth. I do not wish to detract from the clergy when I say this, but you must remember that the clergyman caters to his own little flock, to a group of people who believe exactly as he believes. You and I cater to every living human being; we take care of anybody who is sick, regardless of whether he is Catholic, Protestant, Jewish, or Mohammedan, whether he is white, black, or yellow. We take care of human beings, and it is up to us to restore to those individual beings human dignity. Without belief in something that is bigger and better than he is, I don't see how any man can serve the public well in our profession. All of our science goes out the window when the last hurdle comes up. All of us must die. Our science has made life more livable and we have made longevity something to be desired, although we have created social and economic problems along with our old age problem in this country. But there still does come that last hurdle when all of us must go down to the shore of the river—they call it Styx, I believe, and climb into the boat and go over to the other side. Have we the courage and have we the spiritual incentive, have we kindness to take that individual who no longer can benefit from our science and carry him over that last hurdle with hope, with faith, and with courage? For without these things, we are not physicians.

I would like to congratulate you on the opening of this building, which is dedicated as a temple to the preservation of human life and as a temple to the spiritual values that always go with the devoted, the dedicated physician.

Left to right, facing the camera at the reception for Doctor Hess are: Mrs. Ervin L. Bernhart, Milwaukee; Dr. Gunnar Gundersen, La Crosse; Doctor Hess, and at the far right, Dr. J. J. Boersma, Green Bay.

RECEPTION FOR DOCTOR HES

Visitors to the new building are greeted b Society officers. At the right next to Docto Hess is Doctor R. G. Arveson, Frederic, chai man of the Society Council. To his right is Mr Arveson talking with Dr. L. O. Simenstad Osceola, president-elect of the Society.

Dr. Robert M. Moore, Frederic, greets Doctor Hess in the receiving line at the reception for the A.M.A. president on Friday night, October 14, at the new Society home.

The reception continues. At the left are Dr. and Mrs. F. H. Wolf, La Crosse. Doctor Wolf is a member of the Commission on Prepaid Plans. Going through the receiving line, left to right, are Dr. W. D. Janes, Oconomowoc; Mrs. James; Dr. John Bell, Marinette; Dr. Arthur J. McCarey, Green Bay; and Mrs. McCarey.

. . OCTOBER 14, 1955

Some serious discussion goes on between Dr. arl H. Doege, Marshfield, past-president; Dr. . M. Dessloch, Prairie du Chien, chairman of he Society building committee, and Mr. Francis amb, Madison attorney.

Ready to relax after duty in the reception receiving line are Mrs. Arveson, Doctor Arveson, Mrs. Bernhart, and Doctor Hess. Standing at the right is Doctor Bernhart. Seated to his right is Dr. J. W. Fons, Milwaukee.

Another view of the Council oom and the reception line for octor Hess. More than 200 perons attended the reception to eet Doctor Hess and to tour the cilities of the new building.

THE DEDICATION

of the

Home of the State Medical Society of Wisconsin*

Saturday, October 15, 1955

Doctor W. D. Stovall: If you will come to attention, The Rt. Rev. Father E. J. O'Donnell, president of Marquette University, will now give the invocation.

Father O'Donnell: Oh God, the Father of mercies and of all consolation, we ask from grateful hearts Thy blessing on this undertaking which puts the roof and crown on 114 years of stubborn endeavor. Pour forth the abundance of Thy peace upon this work and upon those whose hereditary faith and persevering devotion and proud accumulation of good works have enhanced not only their own good name but also that of the noble profession to which our state and nation and the whole world are so deeply indebted. Give to them who have shared in so great an enterprise that abiding joy which comes to those who help others rather than themselves. Fill them with a spirit of knowledge and wisdom and love that they may serve faithfully and generously the cause of afflicted mankind. May the latest achievement of this Society's members be only the commencement of their long career of usefulness to humanity and to Thee, so that it will ever be a theme of thanksgiving to their hearts and to their lips that they have been allowed to accomplish so much of the arduous, pleasant, and hopeful toil which has marked their history and shall be their triumphant crown here and hereafter. Amen.

FATHER O'DONNELL

Doctor Stovall: I have the pleasure now of calling upon Doctor E. M. Dessloch, chairman of the Building Committee.

Doctor Dessloch: Ladies and gentlemen: My introduction of the next speaker will be very brief because a plane is waiting for him. I had a 15-page eulogy of him that is of no avail at the moment. Let me say just that it is a great, great privilege to present that eloquent man from Erie, Pennsylvania, who on occasion is a urologist, but more particularly is our spokesman, the Honorable Dr. Elmer Hess, president of the American Medical Association.

Doctor Hess: Mr. Chairman, Reverend Father, ladies and gentlemen: As I was sitting here I just happened to think of something while the Father was saying his prayer. He talked of the word thanksgiving. A few days ago, Dr. Austin Smith (editor, *The Journal of the American Medical Association*) came back from Europe and in talking before a group in Louisville, Kentucky, made this very remarkable statement: "This is my day of thanksgiving. This morning I landed at La Guardia. After I have seen all that I have seen in Europe—and I was back of the Iron Curtain—I come back to this, my America, with thanksgiving—thanksgiving that we are, in America, so blessed with everything that is good." And so I would like to take from the padre's prayer the word thanksgiving, and Austin Smith's statement that it was his day of

* A transcript of the ceremony dedicating the State Medical Society building at 330 East Lakeside Street, Madison, and laying the cornerstone, W. D. Stovall, M. D., presiding.

thanksgiving when he came back to this blessed country, and say to you medical men and women of this great state of Wisconsin, this is your day of dedication and thanksgiving—thanksgiving that you have been able to lead the people in this great state to health and happiness, that you have been able to here build a monument that shall stand forever to represent three things: one, the medical profession and its sacrifice for the people of this country; two, our firm belief in an almighty and supreme God who has favored us with the privilege of serving these, His people, when they are suffering; and three, a rededication, if you please, of our lives in thanksgiving that we have this opportunity. May God bless you all.

DR. HESS

Doctor Stovall: It was indeed a pleasure to have had Doctor Hess with us. Now, I have the pleasure of calling on Dr. L. O. Simenstad, president-elect of the State Medical Society.

Doctor Simenstad: Doctor Stovall, distinguished guests, ladies and gentlemen: You have come here to attend a cornerstone laying and a dedication. I just want you to meet some of the people who have done the work in this undertaking. My job is to introduce the president. I am very glad to do so because he is one of the general practitioners of the State of Wisconsin. He represents all the doctors, not only the specialists. I like it, too, because he comes from Milwaukee, where people are all supposed to be specialists. And what is more, he is the 100th president of the State Medical Society. I have great pleasure in introducing Dr. Ervin L. ("Sarah") Bernhart of Milwaukee.

Doctor Bernhart: Thank you, Doctor Simenstad. Mr. Chairman, Reverend Father O'Donnell, distinguished guests, ladies and gentlemen: Since 1948 the State Medical Society has headquartered on Gorham Street, in a former residence that was renovated to permit its use as an executive office. In those seven years the Society has grown considerably and it has become evident that the old home at 704 East Gorham just wouldn't accommodate the diversified activities of our organization. Today we are here to dedicate our new home, the headquarters of the State Medical Society; and we dedicate it to organized medicine and to the standards which it is pledged to uphold.

DR. BERNHART

At the same time we might say it is in part dedicated to the men who made it possible, to the men who had the foresight, the energy, and the courage to venture into new fields of endeavor. George Crownhart preceded his brother as secretary of this great Society, and George would be justifiably proud today for the dedication of this fine building. One spring evening in 1930 when he attended a meeting of the Milwaukee County Medical Society, George Crownhart addressed the membership on the subject, "What Shall the Future Activities of the State Medical Society Be?" Here 25 years later and just seven days after the anniversary of his 59th birthday, we can see the tangible evidence of the dream which may have been envisioned by George on that memorable evening in Milwaukee.

Our dedication ceremony today doesn't overlook another man whom we have grown to respect for his admirable accomplishments in carrying out his brother's philosophy of

life. Charles Crownhart has stepped into his brother's place and continued those high ideals. His commendable activities are fittingly recognized in this memorable event today. The new home of our State Society is in keeping with the excellent work that has been accomplished by Charlie and his staff, and it will provide an efficient workshop to perform the many services of this Society.

Through the vast growth of Wisconsin Physicians Service, the State Society's Blue Shield plan, together with that of Milwaukee Surgical Care, surgical-medical coverage is provided for over 700,000 Wisconsin citizens. The plan has not only done its job, its bit to necessitate these new quarters; but it is to be credited with a job well done and deserving of the new building in which it is housed. Our Wisconsin Physicians Service is recognized as one of the most progressive Blue Shield plans in the nation, and it is performing an invaluable service to our state. It was my privilege to participate in the ground breaking ceremonies for the Blue Cross building in Milwaukee a few weeks ago. Our companion plan for hospital coverage is also to be congratulated for making this tremendous gain and on helping to safeguard the health of the people of Wisconsin. The significance surrounding these events is indeed indicative of worth-while accomplishment.

Our State Medical Society's new home will also be the home of *The Wisconsin Medical Journal*, the physician placement service, and our varied activities in the fields of health education, public relations, and postgraduate education; and it will be the headquarters for discharging the myriad of duties and responsibilities that are those of an aggressive medical society such as ours in a program for the service and the benefit of the public and the profession.

It is indeed a privilege to be part of this dedication today. In future years we will see continued growth of our headquarters here. It will become more than a building; it will become a symbolizing institution of the high ideals and standards of the medical profession in representing the more than 3,000 physicians in our wonderful state. A deep feeling of humbleness comes over me as I experience the honor of performing the duties of the 100th president of the State Medical Society in this dedication today; and it is a singular honor indeed to be part of the realization of the planning and vision of Charlie and George Crownhart and the many physicians in our state who have worked unceasingly and energetically to make it possible.

Doctor Stovall: Thank you very much, Doctor Bernhart. Now, it is my pleasure to call upon Dr. H. Kent Tenney, past-president of the State Medical Society and member of the Building Committee.

Doctor Tenney: Mr. Chairman, ladies and gentlemen: The office of Attorney General has always been of particular interest to me because my great-grandfather was the first attorney general of the state. I grew up in a family where law and medicine were truly revered professions. I am keenly aware of the State Medical Society's good fortune in having as a friend an attorney who is dedicated to the highest ideals of his profession, who has reached a very high position in his profession, and who is also keenly cognizant of organized medicine's aims and aspirations as it tries to expand its social responsibility while maintaining the individuality of its own responsibility. So I take great pleasure in introducing your very good friend, the Honorable Vernon Thomson, Attorney General of the State of Wisconsin.

Mr. Thomson: Thank you very much, Doctor Tenney. Father O'Donnell, members and friends of the medical association:

MR. THOMSON

This building is undoubtedly a memorial to the State Medical Society's achievements and a monument to individual effort, but may I suggest that it is something more. Could it not, in fact, be the cornerstone of a new philosophy for the medical profession—a philosophy that prescribes a potent role for every physician in the social and economic affairs of our land.

Science has placed amazing weapons in the hands of those who fight disease and physical deterioration. The promises that science makes for the future are almost unbelievable; but what it has done for each physician's armamentarium, this building and the activities it represents will do for the profession's social skills.

Science showed a way to control the epileptic seizure, but the Medical Society offered the legislation which gave the epileptic a chance to live as an ordinary citizen with his new-found freedom.

Jenner's vaccine conquered smallpox, but the Society's Blue Shield and Wisconsin plans are effective antidotes for the economic emergencies of health care.

The atom may soon probe the cancer in its dark hiding place, but it remains for the Medical Society to unseat the boastful quack in his open charlatanism.

Science has contrived to make the human body surprisingly durable, but to what advantage is longevity if the Medical Society cannot help make an aged life more endurable?

The medical profession rests on an incomparable scientific foundation that is preserved here, but the Society has gone one step further with this building. All of Wisconsin can be proud that the profession in this state has seen fit to build a structure which signifies the new and increasingly important role of medicine in the care of the people as social beings.

Doctor Stovall: Mr. Thomson, thank you very much for being with us. I now call upon Mrs. H. W. Christensen, president-elect of the Woman's Auxiliary.

Mrs. Christensen: Mr. Chairman and members of the Wisconsin State Medical Society: You should be very proud of your achievement in this beautiful new building, and sharing in your pride and joy is the Wisconsin State Medical Auxiliary and its president, Mrs. John Boersma. Mrs. Boersma has been active in Auxiliary activities for many years, having served as legislation chairman; nurse recruitment chairman; and, in 1952, State Convention chairman. In addition, she finds time to participate in many community affairs in Green Bay. She is the wife of Dr. John Boersma; and they have three charming daughters, Brenda, 7, Patty, 14, and Barbara, 17. Also, they have furthered the cause of medical education by taking her nephew into their home and inspiring him to become a doctor. With her graciousness and her friendliness, she has made our Auxiliary a happy association for all doctors' wives. I take very great pleasure in presenting to you the president of the Wisconsin State Medical Auxiliary, Mrs. John Boersma.

Mrs. Boersma: Thank you, Mrs. Christensen. Mr. Chairman, Doctor Bernhart, honored guests, ladies and gentlemen: It is with great pride and pleasure that I am here to represent the Woman's Auxiliary to the State Medical Society of Wisconsin at this most memorable occasion. For the past approximately 28 years we as members of the Auxiliary have enjoyed the partnership of our organization and the State Medical Society. We have had as our objectives to assist the Medical Society and its programs for the advancement of medicine and public health in this state and to cultivate friendly relations and promote mutual understanding among physicians' families. Thus we have tried to earn the respect, confidence, and cooperation of our respective communities. Here we are with this wonderful building to house the machinery to carry on the multitudinous tasks of modern medicine today, and how proud we are that the Medical Society and its friends have provided our watchdogs with an efficient environment in which to work. To all the wonderful people who have made this Wisconsin Medical Society building possible we owe a debt of gratitude. For their generosity in making something possible which will be a great benefit to all of us, we thank them.

MRS. BOERSMA

Doctor Stovall: Thank you, Mrs. Boersma. It is wonderful to be associated with such a

great body of women. Now it is my distinct pleasure to call upon my friend, Dr. S. E. Gavin, chairman emeritus of the Council.

Doctor Gavin: Reverend Father, Mr. Chairman, ladies and gentlemen: My assignment today is to escort and present a man whom I believe is probably one of the most important figures in American medicine today and has been for a considerable length of time. He has served years and years diligently in the service of the state and nation and has established a reputation from the county level to the state level, the national level, and the international level. It has been my privilege during those various years to have served with him at many times. The last experience, one of the most happy ones, was as a member of the State Board of Health, of which he was a member and also served as president. I can state without any question of argument—and I have complete knowledge of this particular subject—that there has never been a president of the State Board of Health since he left us who has shown any of the efficiency and ability of our friend, Doctor Gundersen, whom I am very proud and happy to present to you.

Doctor Gundersen: Mr. Chairman, Father O'Donnell, fellow physicians, ladies and gentlemen: As usual, I have no retort against anything that my friend Steve can say. I am delighted to be here today to extend to this group the sincere best wishes of the Board of Trustees of the American Medical Association and the general officers. On behalf of this group I would like to congratulate the State Medical Society of Wisconsin, my Society, for its accomplishments in producing what we thought some years ago would be impossible. I have a personal interest in this matter because when I was serving in the high office of the presidency of the State Medical Society some years ago before it ever had a home, another distinguished attorney of the state of Wisconsin, a friend of the Crownharts, Fred Holmes, who was interested in history, suggested that the State Medical Society should have a home commensurate with its importance and stature in the general picture in the State of Wisconsin. I took up that idea, and was bold enough to suggest it at the time, although then nobody thought it was a possibility. Later on Steve and I exerted further effort, which was unproductive at the time. But ultimately the Society, perhaps feeling it was taking on quite a project, took over the old Collins home on Gorham Street. Presently, of course, this building proved to be too small.

DR. GUNDERSEN

I am very jealous, personally, of this building; and I wrote in the guest book yesterday, Oh, if *we* only had a home. I am talking about the American Medical Association. Of course, we have a headquarters building; but after all it's little more than a large printing plant, and the accommodations are only so-so. I certainly would like to believe that as time goes on the parent organization also will have a home. The American Medical Association, as you all know, is dedicated to a few simple principles; namely, a promotion of scientific medicine and a betterment of public health. I think the State Medical Society of Wisconsin has lived up to these principles very admirably. We heard a great deal here last night and we will hear more today about service. If we adhere to these high principles, these high ideals, I don't believe the State of Wisconsin, the physicians, or anyone concerned has a thing to fear. If we stick to these principles, we will certainly win. If we do less, we lose.

Doctor Stovall: Thank you, Doctor Gundersen. Perhaps some day the American Medical Association will have a fine home of its own in Washington, D. C., where it can really influence legislation. It is my pleasure now to call on Dr. N. A. Hill, a member of the Building Committee.

Doctor Hill: Mr. Chairman, Reverend Father O'Donnell, distinguished guests, ladies and gentlemen: Dr. George F. Lull was to have been our guest here today. Because at the last minute he found that he could not be here, he has sent the following telegram:

"DEEPLY REGRET MY INABILITY TO BE PRESENT AT THE DEDICATION TOMORROW. WISCONSIN IS TO BE CONGRATULATED ON THE ACQUISITION OF SUCH FINE HEADQUARTERS IN WHICH TO TRANSACT THE WORK OF THE SOCIETY. WE ARE ALL PROUD OF THE WONDERFUL RELATIONSHIPS BETWEEN THE STATE MEDICAL SOCIETY OF WISCONSIN AND THE NATIONAL ORGANIZATION AND OUR BEST WISHES GO TO OUR CO-WORKERS IN MADISON. GEORGE F. LULL, SECRETARY AND GENERAL MANAGER, AMERICAN MEDICAL ASSOCIATION."

Doctor Stovall: Now, ladies and gentlemen, as always becomes the prerogative of the master of ceremonies, I would like to say some things to you myself about the State Medical Society, its past record, its future possibilities, and where we are now.

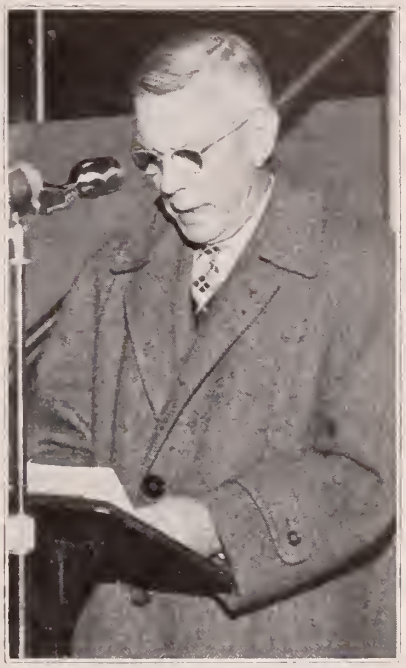
Looking back through the centuries at the development of medical practice is like viewing the mountains in the distance. The peaks stand out. The peaks in this instance represent epochs of medical progress.

February 19, 1841, is not long ago; but it marks the beginning of organized medicine in Wisconsin. On that date an act incorporating the Medical Society of the Territory of Wisconsin was approved by the Territorial Legislature, and the Society was organized in January, 1842.

The records of the doings of these early physicians have been lost, but what was uppermost in their minds is revealed in other records. The last session of the Legislative Assembly of the Territory adjourned *sine die* March 13, 1848. But just 11 days before adjournment, Governor Dodge approved a bill incorporating The Wisconsin Medical College, which was to be located near Milwaukee.

The National Congress, on May 29, 1848, approved a bill admitting Wisconsin to the Union; and almost immediately the state legislature enacted, with the approval of Governor Nelson Dewey, a bill establishing a state University. This act provided that the University should consist of four departments: science, letters and arts; law; medicine; and elementary instruction. Medical education was prominent in the thought of these citizens as well as in the minds of the doctors, as other records clearly bear out. In that session of the legislature "The name of the territorial society was changed to 'The Medical Society of the State of Wisconsin.' "

During the latter part of the century medical science made great progress, particularly in western Europe. It changed medical thought concerning the diagnosis and treatment, control and prevention of many diseases, and engendered new concepts concerning public health practices. To keep pace with these changes the Medical Society, at its annual meeting on May 3, 1887, adopted a resolution regarding the establishment of pre-medical studies which was presented for consideration of the Board of Regents of the University by Dr. J. M. Dodson, later a dean of Rush Medical College. In response to this resolution, the University in 1888 established courses designated, "Special Science Courses Antecedent to the Study of Medicine." This title was changed in 1892 to "Premedical Courses."



DR. STOVALL

Because communicable diseases continued to be a serious threat to the health and life of the people, the Society became interested in the establishment of a State Board of Health, which was created by the legislature in 1876.

The extension of medical care in line with the development of the medical sciences, the improvement of medical education, the building of hospitals, and the advancement of public health measures continued to be important items of business on the agenda of the meetings of the Society. Committees were appointed to work with public officials, and councils were authorized to study various phases of all of these subjects and to

DR. DESSLOCH

DR. TENNEY

look into such subjects as medical ethics and public relations. The function of the Society thus grew at a rapid pace as its influence grew in shaping public policies in matters concerning public health.

World War I broke the relative calm and tranquility of the nation and the state. As we all know, we were soon involved in it. Physicians were needed for the military and to guard the health of those left at home. Doctor Rock Sleyster enlisted immediately in the Army and, because he had for many years been the secretary of the State Society on a part-time and voluntary basis, he was placed in Wisconsin to work with the Society in the selection, for the Armed Forces, of physicians who could be spared from civilian practice.

The functions of the Society had multiplied during and after the war. Now, a full-time executive secretary with the attributes of leadership and administrative skill was necessary to advise with the many committees and the policy-forming bodies of the Society. Mr. George Crownhart was selected for this important position in January, 1923. The choice was not a mistake. He proved to be a wise councilor and an excellent administrator, and to have a courageous spirit in meeting the many difficult and sometimes controversial postwar problems. His untimely death in June, 1941, ended a career that had attained distinction in the field of medical and public affairs.

The postwar years of the 1920's brought many economic and social changes. Then came the depression years during the thirties and, finally, the second World War, which broke upon people who were already war-weary. These epoch-making events brought unrest, much shifting of populations, and the stimulation of ideologies which were mixed with political doctrines calculated to destroy our way of life, restrict freedom of thought, and overthrow our form of government.

Physicians again, as in all other periods in the development of our state, assumed a role of leadership in these critical times.

Fortunately, the Society was organized with strong leadership in its secretary, Mr. Charles Crownhart, who had succeeded his brother in this position.

Public demand for sickness and hospital insurance was pressing. There was no previous experience upon which to calculate the risks, and political organizations and some public officials were proposing compulsory sickness or health insurance as the answer. Time was short. The doctors recognized the necessity of expanding their organization.

In August, 1948, the Society purchased a large residence located on the shore of Lake Mendota as a permanent home and a building in which to expand facilities to meet the problems created by the rapidly changing social and economic order.

In a few years this building was proving inadequate. A committee was appointed which, together with Mr. Crownhart, was to do the planning and the selection of the site for a new building adequate for the expanded and still growing needs of the Society. It is due to the constructive planning and exquisite perception for site selection of this committee and Mr. Crownhart that we are here today to dedicate a building erected on this scenic and historic spot to the progress of medical and public health practices.

DR. HILL

MR. CROWNHART

Cornerstone

A dedicatory ceremony is not only a commitment for the future; it is a commemoration of the past. It has been said that history is the essence of innumerable biographies. It is in this sense that today we recognize that those men and women who have preceded us made preparation by thought and action for the occasion which we are now celebrating. Their conduct and planning made it possible to dedicate this building to continued improvement in the care of the sick and in the health of the people of Wisconsin.

With that we go to the laying of the cornerstone. Mr. Anthony Grignano, the building contractor, will, of course, place the stone; but I have the pleasure of inviting Doctor Dessloch, Doctor Tenney, Doctor Hill, and Mr. Crownhart, who are members of the Building Committee, to come and place the first mortar in the laying of the cornerstone.

[Doctors Dessloch, Tenney, and Hill and Mr. Crownhart took their turns at the trowel in laying mortar for the cornerstone.]

Now, ladies and gentlemen, Mr. Grignano and his helpers will place the stone in order.

Left to right: Doctors Hill and Tenney, Mr. Grignano, Dr. Dessloch, Mr. Crownhart, and Mr. Allen Strang, architect.

STATE MEDICAL SOCIET

Doctor Arveson presides at the recepti dinner for Doctor Hess and the Councilo officers, and members of the Commission Prepaid Plans, October 14. Declared Doct Arveson: "This is a wonderful time for all the men in the Medical Society and, we ho for our friends."

Secretary C. H. Crownhart addresses gue at the dedication dinner on Saturday nig October 15. He said: "Tradition, loyalty, serv mark the professional man. We of the st hope that we can bring, as we serve you in t building, that deep sense of obligation wh we think that the medical profession feels a understands in its service to the public."

At the dedication dinner, Saturday night, October 15, Doctor Arveson presides. At the part of the table in the foreground are Doctor Simenstad, Doctor Fons, Doctor Cunningham, and Doctor Hirschboeck. From left to right in the back: Doctor Gavin, Doctor McDaniel, Doctor Arveson, University of Wisconsin president E. B. Fred, Doctor Bernhart, Doctor Stovall, Doctor Hill and Architect Allen Strang facing the windows, Doctor Dessloch, and Mr. Crownhart. The man behind the scene is handling the public address system.

DEDICATION CEREMONIES

Small groups gathered in every corner at the reception. Here, left to right, are L. R. Wheeler, Milwaukee, Executive Vice-President, Wisconsin Blue Cross; Dr. R. E. Galasinski and Dr. D. H. Witte, both of Milwaukee; and Mrs. Galasinski.

General Contractor Anthony Grignano, Madison, left, gets some help in placing the cornerstone at the dedication ceremony.

A scene from the dedication ceremony. Left to right are Doctor Bernhart; Doctor Simenstad; Mrs. J. J. Boersma, Green Bay, president of the Woman's Auxiliary; Mrs. H. W. Christensen, Wausau, president-elect of the Auxiliary; Attorney General Vernon W. Thomson; Doctor Tenney; Doctor Hess; Doctor Dessloch; and the Very Rev. Father E. J. O'Donnell, Milwaukee, president of Marquette University.

AC

(you probably know every answer!)

Q. Which is today's most widely prescribed broad-spectrum antibiotic?

A. ACHROMYCIN — it's first by many thousands of prescriptions.

Q. What are some of the advantages of ACHROMYCIN?

A. Wide spectrum of effectiveness.
Rapid diffusion and penetration.
Negligible side effects.

Q. Exactly how broad is the spectrum of ACHROMYCIN?

A. It has proved effective against a wide variety of infections, caused by Gram-positive and Gram-negative bacteria, rickettsia, and certain viruses and protozoa.

Q. In what way are ACHROMYCIN Capsules advantageous?

A. For rapid and complete absorption they are dry-filled, sealed capsules (a Lederle exclusive!) No oils, no paste...tamperproof.

Q. Who makes ACHROMYCIN?

A. It is produced — every gram — under rigid quality control in Lederle's own laboratories and is available only under the Lederle label.

HROMYCIN*

Hydrochloride
Tetracycline HCl Lederle

Lederle

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

Two Minnesotans talk with the chairman of the A.M.A. Board of Trustees, Doctor Gundersen. Left to right are Mr. R. R. Rosell, St. Paul, executive secretary of the Minnesota State Medical Association; Doctor Gunnar Gundersen; and Dr. A. O. Swenson, Duluth, president of the Minnesota Association.

Dr. R. E. Galasinski, Milwaukee, explains the Society Seal to (left to right) Mrs. Galasinski; Mrs. E. M. Dessloch, Prairie du Chien; and Dr. H. J. Kief, Fond du Lac. Doctor Galasinski and Doctor J. W. Fons proposed the idea of a Council room flag with the seal. Incidentally, "Medicina Nusquam Non Est" is reliably reported to translate "Medicine is Everywhere."

Council room is comfortably outfitted for small group conversations. A large meeting table accommodates 25 to 30 for Council and special committee meetings.

The Heart of Medicine*

By LOWRY H. McDANIEL, M. D.**
Tyranza, Arkansas

I AM happy to be in the great commonwealth of Wisconsin for this great occasion. May I emphasize early that, while my contacts with your citizenry have been infrequent, the majestic characters of those I have known and admired have been a source of great inspiration through the years. Over 40 years ago I listened with rapt attention to your great Senator La Follette for over three hours at our Redpath Chautauqua, which in those days before radio and television furnished the culture, education, and entertainment for our America. My desire to be a public speaker was born in a Redpath Chautauqua listening to that inspiring leader of your state. Then how often did I get stimulation from that great medical leader, Dr. Eben Carey of Marquette University, in my promotional work of the Phi Chi medical fraternity over 30 years ago. And how valuable and inspirational during the past few years has been the leadership of my dear friend, Doctor Hildebrand of Menasha, in the Academy of General Practice. He wanted to be with us tonight, but right now he is on a national program for druggists in Atlantic City, New Jersey. If this address is a success, may I dedicate it to your great educator and humanitarian, Doctor Stovall.

In thinking of my other true Wisconsin friends, I cannot refrain from quoting the description of a friend that was used by the commencement orator the day I graduated from college: "Oh the joy, the unexplainable joy of feeling safe with a person, having neither to weigh words nor measure thoughts, but pour them all right out, knowing that a faithful heart will take all, grain and chaff alike, keep those that are worth keeping and with the breath of love and friendship blow the rest away."

I also wish to express my admiration for the great men of vision who have made the

building we have just dedicated a reality. I salute them, I praise them, I honor them!

"If with pleasure you are viewing
Any work someone is doing
Tell him now
Don't withhold your approbation
Until the preacher makes oration
And he lies with snowy lilies on his brow.

For no matter how you shout it
He will never know about it
He will not know how many teardrops
You have shed

So if you think some praise is due him
Now's the time to slip it to him
For he cannot read his tombstone
When he's dead."

The subject, "The Doctor's Heart," which, being multiplied, naturally becomes the "Heart of Medicine," is to be approached from a different viewpoint than that ordinarily heard in a scientific or medical program. In discussing the heart of medicine we will go back to the grass-roots and begin with the heart of the individual doctor. Instead of a discussion on the frequency of cardiac disease in the physician, too often

* Presented at the Dedication Dinner, State Medical Society of Wisconsin, Saturday, October 15, 1955.

** Immediate past chairman of the Section on General Practice of the American Medical Association.

brought about by the strains of overwork, lack of sufficient rest and relaxation, exposure, anxiety over the conditions and prognosis of his patients, long and irregular hours and habits, we wish to discuss the spirit, the ideals, the enthusiasm, the ethics, the soul, that inexplainable something that makes the noble physician ever carry on in spite of obstacles that would dampen the ardor or stop any man who did not have "the doctor's heart" or some other human dynamo to inspire him to serve his fellow man.

One of the greatest men in sacred history said that out of the heart come the issues of life. I would like to bring out that out of the "doctor's heart" come the will, the power, and stamina to surge forward in medicine's and humanity's struggle against disease and death.

Much has been said about the strain imposed on the doctor's heart by the practice of his profession. The reference is usually to the physical organ. The doctor's heart of which I speak embraces the intellect, the sensibilities, the intentions, and conscience.

In a deep, time-tested book which most of us revere but read and study too little, it is written that the heart thinks, meditates, reasons, doubts, believes, and understands. All of these are functions of the mind; hence the heart of which I speak includes the intellect. This same book also says the heart fears, hates, deceives, suspects, loves, trusts, sorrows, rejoices, and forgives. These are functions of the emotional nature so the heart includes the sensibilities.

The great literature of the world, sacred and profane, refers to the heart as something which purposes, rebels, conquers, surrenders, or stands steadfast. These are functions of the will; thus the term heart includes all of man's intentions. But that is not all. This spacious word includes something within us that may be made callous or kept tender, something that can restrain, approve, or condemn. These are functions of the conscience, so the doctor's heart of which I speak embraces that celestial spark called conscience.

Having seen that the heart includes the mind, will, emotions, and conscience, it is easy to see that as long as the doctor keeps his heart up he is a winner and that when he loses heart he has lost everything. Bacon, the philosopher, was never wiser than when he said: "All human actions take their color from the complexion of the heart just as the landscapes take their changing hues from the light."

Out of the doctor's heart comes the power to triumph over failures, weariness, lack of appreciation, lack of remuneration, and all sorts of discouragement. The years take their toll of the body; the heart is all we have that we can keep forever young. The ancient Norsemen said that "vain is the strong oak in our ships without strong hearts in our men." One day the poet Longfellow read the words in the book of Proverbs ascribed to King Solomon, "Keep thy heart with all diligence for out of it are the issues of life"; and he made it the basis of an inspiring poem. Everywhere in life, everywhere in human relations, everywhere in man's conduct toward his fellow man there stands towering that great truth: Out of the heart are the issues of life. Multiplying the individual doctor's heart by 200,000, or approximately the number of practicing physicians in America, we arrive at the heart of medicine.

May I tell you a true story—for truth is always stranger than fiction—that so aptly describes the noble physician who puts service to humanity above personal gain or glory. The story has it that a very fine person who was a doctor lived in the suburban section of New Orleans. He did a great deal of practice for the French people of that city. But he did not always reside in the suburban section and certainly did not have his office there. He had his office in one of the most up-to-date office buildings in downtown New Orleans for some years and enjoyed one of the very best practices in the city. His patients during that period of his life were from the richest families in the city. He made large amounts of money and saved a great deal of it.

This physician was a Christian gentleman. He became very much interested in the poor of the city and began giving a part of his time and ability to those who could not pay him. As time went on, he gave more and more of his time to the poor and often neglected his other practice. His paying practice began to leave him; and in time, he lost this practice and then began to spend his savings. He moved his offices into less expensive space in the office building, later moved into still less expensive space, and finally moved out to the suburban section over a

corner grocery store with steps to the outside of the building leading up to his offices. His practice then was almost all charity. A sign, printed on tin and tacked on the lifts of the steps leading up to his office, read, "Dr. M. E. Moffett, Office Upstairs." He never tried to stage a comeback with the rich, but finished his mission on earth with the poor, who paid only small and occasional fees. He died wholly without funds and was buried in an unmarked grave.

A group of the poor but appreciative people for whom he had rendered valuable service, headed by a poor woman for whose son he had performed an operation and corrected a clubfoot, went about trying to collect funds to purchase a small marker for his grave. They worked long hours and hard toward this end but could not get enough money to erect even the most modest marker. Then this lady went back to the store over which the physician's office had been located —the building was then vacant both upstairs and down—and she sawed off a section of the steps with an old hand saw and nailed two upright pieces on the steps. With the help of two small boys, she took that section of the steps to the grave and set it up as a marker at the head of the grave. On the topmost lift of these steps was one of the tin signs which read, "Dr. M. E. Moffett, Office Upstairs." I have little doubt that this eternal address, "Office Upstairs," will apply some day to most, if not all, of the physicians in attendance here today.

In Copenhagen, the capital city of Denmark, there is a statue of the Christ which has gained world fame. The sculptor is the renowned Thorwaldsen. A traveler on the continent of Europe, having heard of this marvelous statue, traveled many miles to see with his own eyes this tremendously inspirational work of art. Arriving at the capital city, the traveler quickly learned the location of the cathedral in which the objective of his journey was to be found. When he arrived at the site, he discovered to his utter unbelief when his eyes first beheld the world-praised statue, that, though meticulously accurate as to form and feature, the statue depicted the Christ in a bowed position, with the face not to be seen. As the traveler stood there with emotions depressingly mixed, a small girl timidly said, "Mister, if you would see the face of Christ, you must kneel at his feet. Kneeling, our friend looked upward and beheld the sublime facial features of the Saviour of Mankind, compassionate, understanding, forgiving. Like all before him, he was deeply moved. Certainly the doctor, if he is to be a true disciple, must so often kneel at the feet of The Great Physician, that one who ever directs the internist's diagnosis or the surgeon's hand. In gazing on that holy countenance he will find the inspiration and the courage to heal and mend his sick and broken fellow man. He will not only be emulating The Great Physician, but he will be exemplifying "the heart of medicine."

The great religions of mankind have ever held and expressed a sympathetic concern for the sick and afflicted. For nineteen hundred years, the heart of the physician has been inspired by the heart of The Great Physician, as the founder of Christianity has been called. The men of our profession are perhaps not fully aware of the compliment paid us in calling the great Galilean The Great Physician. As the Jewish religion inspired care of the sick in the Eastern world, so in the Western world the first hospitals were born out of the compassionate heart of Him whom we call The Great Physician.

When one considers the care of The Great Physician for man's physical well-being, it is not surprising that His first ambassadors built hospices for the sick and retreats for the orphaned and the aged while relaying His message of mercy and His gospel of gladness. The records of their achievements across 19 centuries constitute one of the finest chapters in human history—a history, alas, too much monopolized by wars and man's inhumanity to man. I do not have sufficient time to speak of the almost sublime labors of the medical missionaries in the early years of the Christian era. I would, however, refer to three men whose hearts were touched by the heart of The Great Physician and whose labors have inspired the hearts of many physicians who have read their stories. I refer to these three simply because I know them best. They are representatives of unnumbered thousands in many lands and across 19 centuries.

DAVID LIVINGSTONE

First, I would speak of a Scottish lad, born in 1813. At the age of 10 he went to work in the cotton mills. His hours were from 6 a.m. until 8 p.m. His name was David Livingstone. At the age of 24, David left the cot-

ton mills to study medicine in Glasgow and London. During his youthful years he had read wisely and thought deeply about the best way to invest his life. Under learned and devout Scottish ministers, his heart had been touched by the heart of The Great Physician. On completing his medical studies he left Scotland as a medical missionary to Africa, arriving in the "dark continent" in July, 1841. During the succeeding 15 years his labors were amazing. In addition to teaching and healing, he organized an expedition into the interior and discovered Lake Ngami in 1849 and the Zambesi River in 1851. On another great expedition northward from Cape Town through west central Africa he discovered on the Zambesi River one of the world's greatest waterfalls, which was called by the natives "the smoke that sounds" and which is known to geography as Victoria Falls. He was welcomed back to Scotland and England in 1857 and given honors such as few physicians have received. When he returned to Africa in 1858, he led three great expeditions and discovered lakes and rivers unknown to geography. In 1863, when he returned to England, he published a book on *The Zambesi and Its Tributaries*, with the intent to expose Portuguese slave traders and get missionary and commercial settlements established. Under commission from the Royal Geographical Society, he went back to Africa for the third time to explore the watershed of central Africa and the sources of the Nile River. On one of his expeditions he explored cannibal country and returned almost dying to Ujiji, where he was found by Henry M. Stanley. It is not too much to say that no white man ever so completely won the hearts of the African natives. When Doctor Livingstone died, the natives insisted that his heart, which they considered the seat of his affections, be left with them. So his heart was buried under a tree on which Jacob Wainwright carved the name and date. The natives bore the body through swamp and desert to the sea, through superstitious and savage tribes, with welcome everywhere. The story stands alone in history. And one of the natives loved him enough to brave the voyage across the sea with the body and to stand by the open grave in Westminster Abbey, where the body was laid to rest on April 19, 1874, while the heart of England beat with grief and pride.

FATHER DAMIEN

Next, I would speak of a Belgian priest of the Roman Catholic Church, known throughout the world wherever heroism and devotion are honored as Father Damien. About 1863, he was appointed to the Hawaiian Islands and for nearly 10 years performed the duties of a missionary priest. In 1873, after he had spent 10 years of diligently studying and reading scores of medical books and had had the opportunity to put his knowledge into practice (in 1873 there were few physicians and no medical universities in Hawaii so he was without an alma mater or a degree in medicine, but very likely far more skilled than the majority of physicians at that date), he asked to be sent to the Molokai settlement, where the lepers were segregated. On arrival on "the island of horrors" he found the water supply and the food unfit and the people ill-clothed, ill-housed, and generally wretched. He set about to secure good water, wholesome food, suitable clothing and housing, and medical attention and hospital accommodations. There beat in his breast a doctor's heart, full of love and compassion for his fellow man. He washed their bodies and medicated their sores, conducted religious worship and established schools, erected a shop for leper trade with his own hands, and also with his own hands built a house for worship. He personally dug the graves for hundreds and said for them the ancient service of the church. After 10 years at the settlement he noticed the insensitivity and numbness of his own skin and knew he had contracted the dread disease. After that he began his sermons with the words, "we lepers." He died in 1889, but the memory of his great heart, so like the heart of The Great Physician, will live to warm and inspire other hearts as long as mankind loves goodness and devotion.

DR. ALBERT SCHWEITZER

I speak last of a great contemporary who is regarded by unnumbered people in many lands as the world's greatest living man, and his life as the greatest miracle of our time. I refer to Dr. Albert Schweitzer, who is called by many "the thirteenth apostle." He was born in Kaysersberg, Upper Alsace, on January 14, 1875. His father was a minister and musician. His paternal grandfather was a schoolmaster and organist. Albert Schweit-

zer began his music lessons when he was five, and when he was nine he played the organ for services in his father's church. He became one of the foremost organists of the world and certainly the world's greatest authority on and interpreter of the music of Bach. When his fame as an organist was soaring to international proportions, he entered Strasbourg University to study for the ministry. He not only became a minister, he became a world-famous theologian. In addition to his doctorate in music, he won a doctorate in theology. In 1899 he won a doctorate in philosophy. Before the end of 1899 his book, *Religion Within the Bounds of Mere Reason,* was winning favorable comments around the world—and he was only 24. In March, 1902, he gave his inaugural lecture before the theological faculty of Strasbourg. His books began to have world-wide attention. His book on Bach appeared in 1905 and remains one of the most authoritative works in its field. He gave organ concerts before notable audiences all over Europe. At 30, Albert Schweitzer held in his hands something which many men might give their lives for, and sometimes their souls; namely, the security of a government post, with life tenure; fame as a musician; fame as a philosopher; fame as a theologian; and fame as a preacher. Then, one day he put world fame aside and wrote his family and his friends of his intention to enter medical college to make preparation to go to Africa as a medical missionary. The news was like the explosion of a bomb in Paris, Berlin, Amsterdam, and Vienna. One of the great men of Europe said to him, "You are like a great general going into the firing line with a rifle." "Oh, the waste of it," they said. "Other men without your art and scholarship can go to Africa; a few of your lectures and concerts will pay an army of them to go. The Negro of Equatorial Africa is not your job. Give some lectures and concerts for his benefit, but give yourself to the appreciative people of the Western world. Do not waste your life, do not cast your pearls before swine." To all of this, Schweitzer turned a deaf ear. He entered medical college, where even some of his professors thought they had to deal with a man who had gone crazy. While studying medicine, he published his book entitled *The Quest of the Historical Jesus.*

Schweitzer mastered anatomy, physiology, chemistry, physics, and zoology. After graduation, he went to French Equatorial Africa, with 70 cases of supplies on shipboard with him. That was in the early spring of 1913. He established a hospital in the forest primeval. What has happened there in the 42 years that have rolled by makes a chapter in medical history that glorifies our profession. One of the most versatile men who has lived since Michelangelo and Leonardo da Vinci got his physician's heart from the heart of The Great Physician.

And so down through the centuries, the heart of The Great Physician has inspired the hearts of men and led them to exacting and unremitting service as physicians. It sent Father Damien to Molokai, Carey to India, Livingstone and Moffat to Africa. And you may go today to very remote and needy groups of mankind on our planet, and there you will find those who have turned their backs on all that men ordinarily count dear in order to minister to earth's sorely afflicted children. Happy are we who follow, even afar, in their shining footsteps.

May I tell you another story. A group of American tourists in Dublin, Ireland, passed three workers, each at a rock pile, scattered along the roadside a block apart. In order to make conversation, a tourist said to the first man, "My good man, what are you doing?" Without looking up, and murmuring, Pat said, "Breaking rock." As he approached the second man, the tourist again plied his question; and the answer from Mike was that he was working for the equivalent of a dollar a day. As he approached the third man, who seemed to be watching his rock, rolling it over in his hands, and measuring distances as he worked, the tourist said, "My good man, what are you doing?" And the laborer replied, "Building a cathedral to the glory of God." I like to ponder over that true story and realize that the noble physician who is ever alert to serve his fellow man is constantly "building a cathedral to the glory of God."

We, the physicians of our nation, have an obligation to uphold, an obligation to those great men of medicine whose lives and services stand out so brightly in our history. We pledge ourselves to be true to the ideals of Maimonides, one of the great physicians of all time, along with Dr. Luke the Apostle, *the beloved physician,* and Sir William Osler, the great English master of diagnosis. I can

think of no more useful service in this happy occasion today than to dedicate and rededicate our lives and efforts to the ideals of Ambroise Paré; Benjamin Rush; Pasteur; Harvey Cushing; Walter Reed; Banting; John B. Deaver; John B. Murphy, Howard Kelly of Baltimore, who used to stand on the street corners at night after a hard day in the operating room and preach; John M. T. Finney, that great humanitarian of this century generally admitted to be the most beloved citizen ever to have lived in Baltimore; Wm. Henry Welch; E. T. Ball; Steve Kenyon of Georgia; M. C. Winternitz; Nicholas Senn; Moorman of Oklahoma; Matas of New Orleans; and R. L. Sanders of Memphis. My choice as America's greatest living citizen is Jonas Salk, who remains humble in spite of honors, as did Sir Alexander Fleming.

The mention of one name brings many more to our minds. The great state of Wisconsin can offer its Drs. Charles Bardeen, S. E. Gavin, Eben Carey, W. D. Stovall, E. L. Bernhart, R. G. Arveson, Wilson Cunningham, Gunnar Gundersen, William Beaumont, Ludvig Hektoen, and the great Billings. While the Mayos, the Oschners, and the Criles are not from Wisconsin, they too should be honored.

* * *

I cannot think of a better way to close this dedicatory address than in the words of Dr. Frank Crane's notable "Prayer of the Physicians: We pray, O God, that we may have absolute intellectual honesty. Let others fumble, shuffle and evade, but let us, the physicians, cleave to the clean truth, assume no knowledge we have not and claim no skill we do not possess. Cleanse us from all credulities, all fatuous enthusiasm, all stubbornness, vanities, egotism, prejudices, and whatever else may clog the sound processes of our minds. These are but dirt; make us living personalities as aseptic as our instruments.

"Give us hearts, but let our feelings be such as shall come over us as an investment of power, to make our thoughts clear and cold as stars and our hands skillful and strong as steel. Deliver us from professionalism, so that we may be always human, and thus minister to sickly minds as well as to ailing bodies. Give us constant realization of our responsibility, for people believe in us and into our hands they lay their lives. Let us, of all men, be sober and walk in the fear of eternal justice. Let no culpable ignorance of ours, no neglect nor love of ease, spoil the worth of our high calling.

"Make our discretion strong as religion, so that the necessary secrets of souls confiding in us may be sacredly kept. Give us the joy of healing. We know how far short we may be of being good men; but dear God, make us good doctors. Give us that love and eagerness and pride in our work without which the practice of our profession will be more fatal to us than to those under our care. Give us a due and decent self-esteem, that we may regard no man's occupation higher than ours, envying not the king upon his throne so long as we are prime ministers to the suffering.

"Deliver us from playing at precedence, from hankering for too much praise and prominence, from oversensitiveness, and all such forms of toxic selfishness." Give us a just remuneration for our endeavors or an adequate honorarium as our beloved Dr. Elmer Hess calls it, "not so little that we cannot have the leisure we need to put quality into our service; not so much that we shall grow fat in head and leaden in heart, and forsake our sense of ministry for soft indulgence. Give us courage, but hold us back from overconfidence."

And, dear God, may I add just one personal petition in this prayer. Wilt Thou in Thy infinite grace answer the prayers of 160,000,000 Americans who, regardless of race, creed, or political affiliation, are earnestly beseeching the restoration of our great President that he can continue to lend his efforts toward that one ideal so sorely needed by an unhappy and suspicious world, peace on earth and good will toward all men.

"Let us so discharge the duties of our office that we"—every member of the medical fraternity—"shall not be ashamed to look any man or woman in the face. And when at death we lay down our task, may we go to whatever judgment that awaits us, strong in the consciousness that we," individually and collectively, representing that great and total heart of medicine, "have done something toward challenging and conquering the innumerable tragedies of life. Amen."

(Portions of this address have been printed previously in other publications, as parts of presentations by Doctor McDaniel.)

SIDE LIGHTS ON DEDICATION

DR. S. E. GAVIN, Fond du Lac, chairman emeritus of the Council, speaking at the dedication dinner, October 15: "Fifty-six years ago, I entered practice in Fond du Lac. I joined the Society in 1899. The dues at that time were pretty good—a dollar a year. We went along on that basis for a good many years, and finally dues went up a little. All business of the Society at that time was done in the office of Doctor Sheldon, who was secretary. After several years, a couple of states had the idea of an executive secretary. I was a delegate to a meeting in Madison when it was proposed that dues be raised to $15 and a full-time secretary employed. After one of the worst battles I have ever seen in the House of Delegates, it was approved; and, of course, George Crownhart was employed. I went into the Council about that same year and later on became chairman of the Council. I think George developed the idea of a home for the State Medical Society. He was first located in Milwaukee in a little room but finally came to Madison. Late in the 1940's, the Council culminated the matter; and we decided to buy the home on Gorham Street. We got there, and it really was a home. We had hardly gotten there when we needed more space. I had looked forward to that home for so long I could hardly bear the idea of giving it up and establishing the new building. Now I realize that this was the right thing to do without any question. The only suggestion I have is that we go back to calling this a home—not the State Medical Society building. It is so easy to establish the physical thing without any sentiment at all, but I would like very much to revise the idea of calling this a building and call it the home of the Wisconsin State Medical Society, which it is; and I am sure it will be for a long time."

* * *

C. H. CROWNHART, Madison, secretary, speaking at the dedication dinner, October 15: "It is with something more than satisfaction and pride that your staff of the Society occupies this building and tries to bring into it the dignity and the future and the honor and the integrity of the medical profession which the staff represents in its various contacts with legislators, state servants, and the public. We think of our employers not only as a group of men with tradition and history but as a group of men with a great future and a great responsibility. If we thought otherwise, it would be a trade organization developed and organized to promote a purely selfish interest. But no profession having at heart compassion and the welfare of the public can ever place the dollar mark ahead of loyalty, nor can it ever place ahead of loyalty the great obligation that it has to the people it serves, whether that profession be the ministry, medicine, my own, or many others. Tradition, loyalty, service mark the professional man. We of the staff hope that we can bring, as we serve you in the building, that deep sense of obligation which we think the medical profession feels and understands in its service to the public. We are here in but a transitory period, but whoever serves you can do no other than to say it has been a privilege. It will always be a privilege, and we honor you for the work you do."

* * *

DR. J. S. HIRSCHBOECK, Milwaukee, dean, Marquette University School of Medicine, speaking at the dedication dinner on October 15: "On behalf of the faculty, the students, and alumni of Marquette University School of Medicine, I want to congratulate the State Medical Society on the planning, direction, and finally the completion and occupation of this wonderful building. It is sort of like someone in your own family congratulating the other members of the family on having done a fine job, but I am sure that the graduates of all medical schools who are practicing in the State of Wisconsin can't help but feel the fraternity of spirits which we do have in the State of Wisconsin today; and I think this augurs well for the future."

COMMENTS FROM THE GUEST BOOK ON DEDICATION DAY:

"We are meeting today in our new building, 'our home.' It has been a labor of love, devotion, and vision of a handful of devoted men." *R. G. Arveson, M. D., Frederic, chairman of the Council.*

"It is finished. We submit this, our best effort, for your critical approval and hope you'll be eternally proud as we are of this 'Our Home.'" *E. M. Dessloch, M. D., Prairie du Chien, councilor, chairman of the Commission on Prepaid Plans, and chairman of the Building Committee.*

"The building is finished, but its contribution to the Society is just starting." *H. Kent Tenney, M. D., Madison, past-president.*

"In this year of our 114th Anniversary, after careful planning, not cursory, marking completion of our home which we can call our very own, congratulations to all." *Jerome W. Fons, M. D., Milwaukee, speaker of the House.*

"A long cherished dream has come true. May Wisconsin medicine continue to grow to even greater heights in the days to come." *Harry and Irene Kasten, Beloit. (Doctor Kasten is a councilor and a member of the Commission on Prepaid Plans.)*

"We extend to the State Medical Society hearty congratulations and best wishes for a prosperous and happy future in this new 'dream' building of which they can be very proud." *Arleen and Arthur McCarey, Green Bay. (Doctor McCarey is immediate past-president of the Society. Mrs. McCarey is a former president of the Woman's Auxiliary.)*

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: H. C. Dangle, M. D.

REPORT OF A CASE*

A 45-year-old white male, a machinist, was admitted to the hospital complaining of progressively severe epigastric pain of several months' duration. The pain usually occurred at night and lasted one to two hours. The patient described it as a deep boring pain; drinking milk usually relieved it. Occasionally he vomited, but he never noticed blood. He had lost 35 pounds in the preceding eight months. Upper gastrointestinal x-rays done elsewhere were reported as normal.

The patient was well developed and well nourished. His blood pressure was 150/80, his pulse 86, and his temperature 99.6 F. Slight epigastric tenderness was noted. The liver, spleen, and kidneys were not felt. No abnormal masses were found. Rectal examination was negative. No neuromuscular abnormalities were observed.

At the time of the patient's admission the hemoglobin was 16 Gm., the erythrocyte count 5,500,000, and the white blood cell count 13,350. There were 40 neutrophils, 40 stabs, 1 juvenile, 14 lymphocytes, and 1 monocyte. The urine was negative. Serum amylase was 33 amylase units per 100 ml. An electrocardiogram was normal.

An oral cholecystogram, an x-ray of the abdomen for bowel shadows, and fluoroscopic examination of the esophagus with a barium meal were all normal, as was the mucosal pattern of the stomach. A penetrating ulcer was seen in the duodenum; it projected superiorly and posteriorly, involving the pancreas. No radiopaque densities were noted in the region of the pancreas. Two diverticula were visualized in the duodenum, the larger in the descending loop and the smaller in the superior aspect of the third portion.

The patient was kept under observation for seven days, and then he was operated upon. The gallbladder was thin-walled and contained no stones. The superior and posterior surfaces of the duodenum were extensively scarred. An ulcer, penetrating into the pancreas, was found immediately beyond the pyloric valve. About 4 cm. distal to the pyloric ring was a thin-walled diverticulum which lay almost entirely in the substance of the pancreas. An anomaly of the transverse colon placed it in a retroperitoneal position.

Three-fourths of the stomach and the proximal 4 cm. of the duodenum with its diverticulum were resected. The duodenum and diverticulum were dissected from the pancreas with difficulty. Because of the anomalous transverse colon, an antecolic gastrojejunostomy was done. The duodenal-jejunal junction was farther to the left than normal. Because of this, the jejunum was anastomosed to the stomach in reverse of the usual manner so the distal portion of the jejunum was at the lesser curvature of the stomach.

Following surgery the patient was maintained on Wangensteen suction. On the fourth postoperative day his temperature rose to 103.6 F. and his pulse to 120. He became cyanotic, lethargic, and confused. Evidence of consolidation at the base of the left lung appeared, and an x-ray of the chest showed areas of density in both lung fields. A tender mass was felt in the right upper quadrant of the abdomen. The serum amylase at this time was 474 amylase units per 100 ml. From the sputum Staphylococcus aureus was cultured, along with *Neisseria*, alpha streptococcus, and *Pseudomonas aeruginosa*.

From then on, the patient's condition steadily deteriorated. On the seventh postoperative day mild jaundice appeared, and weakness of the left arm and leg with hyperreflexia on the left and a positive Babinski on the left developed. On the eighth postoperative day the bowel sounds were absent. The densities in both lungs, as seen on x-ray, persisted in spite of antibiotic therapy. Terminally the temperature rose to 107 F.

* From St. Joseph's Hospital, Marshfield.

The patient expired on the twelfth postoperative day.

Dr. C. A. Vedder: When this patient recovered from anesthesia on the day of operation, it was almost immediately apparent that he was not following the usual postoperative course. He complained almost at once of excruciating epigastric pain, which morphine failed to relieve to any appreciable degree. The level of amylase was up and although pancreatitis of mild degree follows many surgical procedures in this area, it was believed that the degree of elevation in this case indicated a severe pancreatitis. The surgical removal had been difficult, requiring tedious dissection of the ulcer and diverticulum. The latter structure was removed to facilitate freeing the duodenum sufficiently for secure closure of the stump. Bleeding was not difficult to control, and there was no apparent gross leakage of the pancreatic juice from the operative site.

Dr. G. E. Magnin: I saw this patient preoperatively and postoperatively. The deep boring pain which he had suggested that there might be a chronic pancreatitis associated with a penetrating ulcer, but the amylase preoperatively was normal. The mass found on the fourth postoperative day was tender, was about 10 cm. in diameter, and was assumed to be related to the pancreatitis and probably due to necrosis of fat. The neurological findings were unexplained. They persisted to the time of death. It was my opinion that they were not the result of thrombosis.

Clinical Discussion

Dr. R. S. Baldwin: The postoperative course undoubtedly can best be explained on the basis of pancreatitis. The presence of a blowout of the duodenal stump might also explain the abdominal findings. If the changes in the lungs on x-ray and the cerebral symptoms were due to embolism, fat might be suspected as the agent since it will pass through the pulmonary circulation. If the pancreatitis was due to bacterial contamination of the abdomen with abscess formation, the changes in the lungs and brain might have resulted from bacteremia with septic embolization. The sudden onset of the left hemiplegia indicates the disturbance was probably in the right internal capsule. No mention is made of sensory changes, so we can assume perhaps the anterior limb of the internal capsule was principally involved.

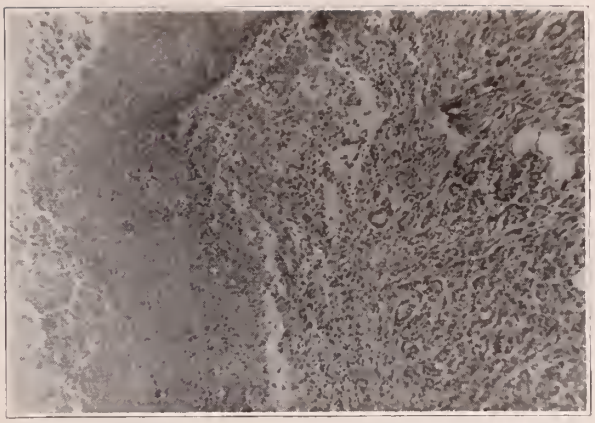


Fig. 1.—Section of body of pancreas showing surrounding area of fat necrosis. The pancreas shows inflammation only at the periphery.

Necropsy Findings

Dr. H. C. Dangle: The peritoneal cavity contained about 400 cc. of turbid, odorless fluid. The mass felt on the fourth postoperative day was found to be swollen degenerated omentum, which was adherent about the head of the pancreas. The loops of bowel were of normal caliber and were bound together by fibrinous adhesions. No leakage was found about the duodenal stump or the gastrojejunostomy stoma. The exposed portion of the head of the pancreas was necrotic. The body and tail appeared normal (Fig. 1). In microscopic sections evidence of acute pancreatitis was found only in the head. The fat surrounding the pancreas was in a state of advanced necrosis. The retroperitoneal involvement spread inferiorly to the rim of the pelvis and was especially marked about both adrenal glands and kidneys. The ducts of Wirsung and Santorini, the gallbladder, and the extrahepatic bile ducts were normal. The left adrenal gland had interstitial hemorrhage and fat necrosis of the cortex. Dependent atelectasis and focal areas of bronchopneumonia were found in both lungs. The brain had multiple foci of softening in the right parietal cortex and in the right internal capsule. Microscopically (Fig. 2), the arterioles in the right cerebral hemisphere and also on the left, to a lesser degree, showed a peculiar smudgy basophilic necrosis of the media and adventitia, with marked karyorrhexia accompanied by a mild infiltration of leukocytes. Eosinophils were not

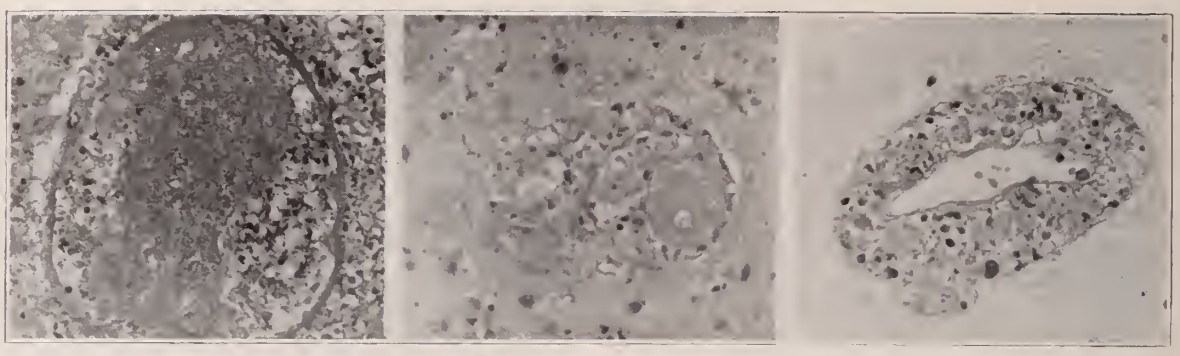


Fig. 2.—Sections of cerebral arterioles showing necrosis and thrombosis.

found. The intima of the vessels often appeared intact as a dense eosinophilic ring, and many of the vessels contained eosinophilic thrombi. Occasionally the vessels were surrounded by small hemorrhages and rings of degenerated basophilic glial tissue. The lesions of the cerebral arterioles and the perivascular necrosis were similar to the areas of chemical necrosis of vessels about the pancreas. More distant from vessels, the encephalomalacia was like that in ischemia. No vascular lesions were found in other organs. No fat emboli were present in the lung, kidney, or brain; and no degenerative changes of renal tubules were noted.

Discussion

Digestive changes attributable to pancreatic enzymes in distant areas have been reported previously in acute pancreatitis. Subcutaneous fat necrosis has been most commonly mentioned. Occasionally there is digestion of the extrapleural and mediastinal fat, most often on the left side.[1] Presumably lipase is carried to the thorax by the lymphatics. In one case of acute pancreatitis[2] there was widespread cerebral demyelination with slight neuronal destruction and there were focal areas of necrosis of the myocardium, adrenal glands, and an ovary. The lesions were believed to be identical with those induced experimentally in animals with a pancreatic lipase preparation. Vascular changes were not found.

Vessel digestion occurs locally in pancreatitis but has not been found in other organs. Rich and Duff[3] described a type of vascular necrosis which they believed accounted for the bleeding within the pancreas in acute hemorrhagic pancreatitis. They attempted to show that this was due to trypsin. Their description is quoted since it seems to describe the lesions in our case. "The adventitia of the affected artery or vein may appear condensed and pink-staining and may contain leukocytes or necrotic cells, but the striking changes are in the media. The muscle fibers of the media swell and are sometimes separated by a pink-staining fluid or by spaces in which nothing stains; their nuclei become shrunken, pyknotic and often karyorrhetic, and polymorphonuclear leukocytes may be found in the lesions in the early stages. The internal elastic lamina loses its undulation and takes on a swollen appearance. Individual fibrils split off so that the elastic membrane appears frayed. Finally, all nuclear staining is lost, and the necrotic tissue of the vessel wall stains homogeneously pink." Rupture of the necrotic vessel with hemorrhage was frequently seen. Similar lesions were produced experimentally by these authors with subcutaneous injection of trypsin and by the use of pancreatic juice without enterokinase.

Until recently little attention was given to the levels of trypsin in the blood and the part such levels might play in the course of acute pancreatitis. Rush and Cliffton[4] have shown that in experimental acute pancreatitis the serum contains an increased tryptic and antitryptic activity. A means of measuring these substances in the human blood was found. Patients recovering from pancreatitis had a rise of antitrypsin comparable to the rise which occurred in animals following the injection of trypsin. The shock in experimental acute pancreatitis was felt to be due to the increased tryptic activity.

The disturbance of the clotting mechanism associated with carcinoma of the body

and tail of the pancreas has been attributed to trypsin. With repeated intravenous doses of the enzyme in animals, marked depletion of fibrinogen and bleeding can be produced. A case of fibrinogenopenia with massive gastrointestinal bleeding in carcinoma of the body of the pancreas has been reported.[5] A fibrinolytic substance from the pancreas was suspected as the causative agent. On the other hand, trypsin, if given rapidly intravenously in experimental animals, has a thromboplastic effect and will produce massive intravascular coagulation. Gore[6] has postulated that the thromboses peculiar to neoplasms of the body and tail of the pancreas are due to the release of trypsin from the disrupted pancreatic tissue surrounding the neoplasm. He has shown that there is a smoldering low-grade pancreatitis at the advancing edge of carcinomas of the pancreas which would facilitate the escape of the enzyme into the blood. Gore believed that there might be a gradual depletion of the antitryptic substances with accumulation of active trypsin within the blood, resulting in thrombosis. The usual absence of thrombotic phenomena in acute pancreatitis was believed to be explained by the fact that the process is not of sufficient duration to deplete the antitryptic substances of the blood. Vascular reactions such as those seen in the brain of this patient can arise from a variety of causes. These changes certainly are not specific. However, it is interesting to speculate whether the thromboses which occurred in our patient were not due to the thromboplastic action of trypsin and whether the thrombi, possibly containing a large quantity of trypsin, might not have produced the necrosis of the vessel walls.

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POSTGRADUATE CLINICS AT MILWAUKEE COUNTY HOSPITAL

All physicians are invited to attend the first in a series of postgraduate clinics, to be held at the Milwaukee County Hospital, 8700 West Wisconsin Avenue, on Saturday, December 10, from 10 a.m. to noon.

A symposium on diseases of the thyroid, with presentation of illustrative patients, will be held. Those taking part, and their presentations, include:

Dr. Francis Murphy—discussion of a patient with "masked" hyperthyroidism whose presenting complaints were those of congestive heart failure; Dr. George Hellmuth—auricular fibrillation in hyperthyroidism; Dr. William Engstrom—a patient with Hashimoto's struma treated with desiccated thyroid, one with thyroiditis treated with cortisone, and one with hyperthyroidism occurring during pregnancy; Dr. Erwin R. Schmidt—discussion of a patient with orthopnea and signs and symptoms of congestive failure due to a large intrathoracic goiter and two patients with hyperthyroidism; and Dr. John Huston—coronary blood in thyroid disease.

Luncheon will be served to visiting physicians by the hospital at cost. There is no admission fee for the clinics.

MILWAUKEE ACADEMY OF MEDICINE

Guest speaker Rene J. Dubos, Ph.D., Head of the Department of Bacteriology, Rockefeller Institute for Medical Research, will discuss "Physiological State and Susceptibility to Infection" at the December 20 meeting of the Milwaukee Academy of Medicine. The meeting will be held at the University Club. Preceding the scientific meeting at 8 p.m., there will be cocktails at 6 and a dinner at 6:30.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison *

TREATMENT OF TETANUS

While clinical tetanus is not a very common disease, it does appear from time to time and probably will continue to do so. Treatment of the developed disease is still far from satisfactory; the mortality rate is very high—from 25 to 50%. Gilbertsen and Arhelger[1] suggest the administration of tetanus antitoxin in doses of from 5,000 to 10,000 units, while Christensen[2] feels that 15,000 to 30,000 units should be given as soon as possible after the accident. Still larger doses should be used when the wounds appear to be badly infected. In these cases, more than "enough" is probably justified.

It may be worth while at this point to recall the fact that tetanus toxoid is an immunizing preparation and useless in therapy of acute tetanus. One should consider it to be somewhat analogous to the use of vaccinia for smallpox. The toxoid is solely a stimulus to the processes of production of immunity and is not an agent useful for the developed disease. It is the antitoxin that possibly may be lifesaving in instances of early tetanus, characterized by signs of trismus or muscle spasms subsequent to the patient's having received a dirty wound. Unfortunately, neither antitoxin nor any other known agent or means can effect a removal of the toxin from nerve tissue so as to make it subject to neutralization by antitoxin. Yet it appears clinically useful in certain instances, most likely due to stopping further poisoning through antidoting the toxin in the sites of development in infected wounds or in the circulation prior to its becoming fixed in nerves.

All authorities stress the absolute necessity of thorough débridement of the site of infection—even to be more than "thorough!"

Once the toxin has reached the nerves of the central nervous system, the agents above mentioned are relatively ineffective; hence, attempts must be made to keep the patient alive so that, with time, he can counteract the intoxication of the central nervous system by his own defensive processes. All patients do not die from the consequences of the infection.

Adriani and Kerr,[3] professional anesthetists, report on the results of their studies on the treatment of tetanus. When first seen, the patients with signs of tetanus are treated with antitetanic serum, penicillin, and an effective sedative. The wound is débrided as soon as possible, and a tracheotomy tube is inserted after application of local anesthetics. Thiopental may be administered intravenously if and when needed. Sedatives such as secobarbital, pentobarbital, amobarbital or other short-acting barbiturates may well be employed. A muscle relaxant such as mephenesin, a presumed internuncial nerve depressant, may be given intravenously for prompt action of relatively short duration. This drug may also be administered through a Levine tube passed into the stomach, or it may be given rectally. The dosage of the drug is determined by the need, and even as much as 5 Gm. may be given in order to effect an adequate grade of relaxation.

Chlorpromazine appears to add a useful factor; namely, to make the relaxants more effective. Doses of 25 to 30 mg. of this drug in a concentration of 5% should be injected intravenously quite slowly, *i.e.*, throughout a period of approximately 10 minutes. The exact dosage of the drug, like that of many other drugs, must be gauged by the responses produced.

Adriani and Kerr hesitate to make any special claims of success in their therapeutic experiences in the treatment of tetanus and even suspect that, after all, the most important feature of their therapy might well be tracheotomy and the proper use thereof.—A. L. TATUM, M. D.

* Doctor Tatum died on November 11, 1955.

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Chest X-rays Should Be Routine

As It Looks to Your State Board of Health

THE word "routine" has an unpleasant connotation for many of us. It suggests wearisome sameness of action; boring monotony in work; or tedious, time-consuming minor tasks. It is not the connotation to apply, however, when we're thinking about the routine chest x-rays, much as we've read and talked about them during the past decade.

Ideally, x-ray study of the chest should be recommended for everyone at regular intervals such as once a year. Such a "routine" is most likely to find disease in its early stages when there is a good opportunity for recovery and before any great amount of permanent damage has occurred. Combined with the physical and appropriate laboratory examinations, the routine chest x-ray can disclose unsuspected cardiovascular disease and lung cancer as well as tuberculosis. In spite of the general acceptance of the idea that an annual x-ray is good, records show that only one of every six eligible persons in Wisconsin actually does get a chest x-ray in any given year.

Ideally, also, chest x-rays should be taken routinely of each patient who is admitted to any hospital or institution. Such a policy can be extended to outpatients as well and certainly would include all employees, both professional and nonprofessional. Of the 160 general hospitals in Wisconsin, 30 now require admission chest x-rays. Fifty-eight of the remaining 130 said in 1954 that they contemplated starting this service in the future. Of the hospitals now requiring x-rays, 14 use equipment loaned by the State Board of Health.

The value of admission chest x-rays can be judged from several angles, one of the most important being health protection for staff and employees. Experience shows that four times as many cases of tuberculosis are found among patients admitted to a general hospital as among the general public. If no effort is made to find and properly treat these cases, the increased risk of infection is obvious. The hospital's potential liability is increased because tuberculosis so acquired is considered an occupational disease and can require compensation payments.

The routine chest x-ray can be a tool to help improve public relations for the hospital or institution. Patients need to understand its value and to consider it part of the hospital's program of admission tests which aid in diagnosis and treatment. In fact, to leave it out could be a sign of indifference or neglect.

To the physician, the routine chest x-ray of his patient may disclose a condition which would completely alter the mode of treatment ordered for the current hospitalization. He is in the key position to follow up suspicious films and to establish a definite diagnosis. And he will need to see that suitable precautions are taken when contagious disease is found. The admission film also can provide a basis for comparison should the patient be hospitalized in the future. In this connection, it can be noted that the routine x-ray film can be an additional source of evidence in the event of malpractice suits or where discovery of hidden chest disease after death encourages charges of negligence.

Because routine chest x-rays are not carried out on anywhere near a universal basis, screening programs which emphasize groups most likely to be infected, such as hospital admissions, are our best tool. Another such large group includes persons over the age of 45, in whom incidence of tuberculosis is four to six times as great as in younger persons. Members of this group serve as a source of infection for the younger generation in their own families and in their communities. In this age group, deaths due to tuberculosis occur much more often among men than among women.

This older group not only has more tuberculosis but is the group most frequently hospitalized for other illnesses. Cancer of the lungs and heart disease are more frequently found among members of this group than among those of other age groups. They're also the people most likely to view the "routine" x-ray by itself as more of an inconvenience than a necessity. Making it a part of every complete physical examination and hospital admission can be one step in overcoming this feeling.—MILTON FEIG, M. D., M. P. H., *Acting Director, Division of Tuberculosis Control.*

Facts about

"THE DOCTORS' PLAN"

THE BLUE SHIELD PLAN
OF THE
STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON PREPAID PLANS

Experiment in No Fee Schedule—No Income Level Contract

A contract which is based on a new concept of approaching the problem of patients who want more coverage; of physicians who desire adequate insurance reimbursement from all levels of income population; and of Blue Shield, which seeks to find simplified methods of writing national accounts, has recently been installed by Wisconsin Physicians Service for a large group in Racine.

The new contract provides:

(a) Payment of *reasonable* charges made for surgical services;

(b) Payment of *reasonable* charges made by the attending physician for miscarriages, cesarean or Porro-cesarean sections;

(c) Payment of a $100 maximum indemnity benefit for all other maternity services;

(d) Payment of *reasonable* charges made by physicians for in-hospital medical service, for a period not to exceed 120 days of hospitalization per illness;

(e) Payment of daily charges (up to $5 for home care, up to $3 for office care) for home and office medical services. The total such benefit per illness shall be $250 per calendar year;

(f) Payment of *reasonable* charges made by the attending physician for x-ray, except therapeutic, and laboratory services;

(g) Payment of *reasonable* charges of a physician for anesthesia services associated with surgical or maternity services;

(h) Reimbursement for ambulance expense, not to exceed $10 per trip.

The Commission on Prepaid Plans authorized this contract as a trial to determine the feasibility of the "reasonable charge" approach to insurance. The policy has no fee schedules or income levels. Where the benefit is payment of "reasonable charges," a charge will be considered "reasonable" if it does not exceed the general level of charges by other physicians who render such services under similar or comparable circumstances within the community in which the charge is incurred. A charge is incurred on the date the professional service is rendered.

The program at Racine will cover approximately 1,000 hourly employees and 300 salaried employees.

For Information or Advice

Write • P. O. BOX 1109, MADISON, WIS. Phone • ALpine 6-3101 MADISON, WIS

THE MEDICAL FORUM

COURT VICTORY BIG BOOST IN FLUORIDATION FIGHT

Physician-Employers Subject to New Tax on Jan. 1

Madison, Nov. 23—Beginning Jan. 1, employers, including physicians, who employ four or more persons for some portion of the day on at least one day in each of 20 weeks, are subject to both state and federal unemployment insurance levies.

The combined state and federal tax is three per cent of the first $3,000 of annual wages paid to all employes, with 2.7 per cent payable to the state and .3 per cent to the federal government.

Reports and payments to the federal government are due by Jan. 31 of the subsequent calendar year. Reports and payments to the state are due quarterly, in April, July, October and January. These are due regardless of whether the employer has been notified by either of the governments, or has received tax forms.

Here's the procedure to follow:

Just as soon as an employer has employed four or more persons in any portion of each of 20 weeks he should notify the Unemployment Compensation Division, 137 East Wilson street, Madison, in order that prompt payment may be made of state taxes owing from the beginning of the year. At the same time, he should request appropriate form from the Director of Internal Revenue, Post Office, Milwaukee.

Some physicians and others have indicated they plan to substitute a full time employe to replace two part-time employes—and thus keep below the four-employe level. It is possible to place part-time bookkeepers who work independently without direct supervision on a fixed fee basis, and thus made an independent contractor. Attorneys also suggested that professional employes could have their status changed to that of partners as another means of keeping under the four-employe level.

Legal queries concerning the tax should be directed to attorneys.

OBITUARIES OF DOCTORS REVEAL STARTLING FACTS

Hartford, Conn., Nov. 29—Some interesting and startling facts were revealed in a study of 144 obituaries of local physicians, conducted recently by the Hartford County Medical Society.

For instance:

One of every eight physicians who died between 1940 and 1953 was in debt at time of death.

One of every three left net assets of less than $10,000.

Only one doctor in every eight survived his wife!

Doctors aged 40 to 50 died twice as fast as the general population, and in the 60-70 bracket, the MD's death rate was 50 per cent higher than the insurance table.

Only one doctor died extremely wealthy, and $575,915 of his estate was consumed by taxes and other settlement expenses. Expenses of settlement of all estates studied ranged from a minimum of 13 to 33 per cent.

One out of every three physicians left no will!

Heart diseases and cerebral hemorrhage were the chief causes of death.

Proposed Health Insurance for Federal Employes Studied

Washington, Nov. 21—Because it anticipates enactment of legislation in 1956 authorizing contributory health insurance for federal employes, the Civil Service Commission is proceeding with details of implementation. A pending bill stresses freedom of choice—Blue Cross, Blue Shield, group practice clinics, indemnity-type coverage plans and the like.

The Commission said the study involves "nightmarish" administrative problems which must be answered before Congress takes up the measure early next year.

Dental Caries Public Health Problem, High Tribunal Decides

By JOHN P. DESMOND

The fluoridation of public water systems as a lawful means of combating dental caries won a clear-cut victory this year in the Wisconsin Supreme Court's disposition of *Froncek vs. Milwaukee.*[1]

Wisconsin dentists, through their state and national societies, have given unselfish support to this method of fighting the commonest of all dental ills. Fluoridation offers them no private gain. Only a genuine professional zeal can explain the leadership they have taken in this public program for the promotion of dental health. They now have the satisfaction of knowing that the law approves their line of attack.

ORDINANCE CHALLENGED

The *Froncek* case arose when a group of citizens representing a wide variety of interests challenged the legality of Milwaukee's fluoridation ordinance. They put up a strong argument, relying on some of our most fundamental legal and political concepts. The court met the argument head-on, making the victory all the more impressive.

The citizens' group argued that

(1) Caries is a private health problem, not a proper subject for public health legislation;

(2) The city had unlawfully invaded the private practice of dentistry, medicine and pharmacy; and

(3) The city had infringed certain of its citizens' fundamental rights, including:

(a) the right to be free from medical experimentation,

(b) the right to treat one's health as one deems best,

[1] 269 Wis. 276, 69 NW 2d 242 (Decided, March 8, 1955).

(Continued on page 570)

FLUORIDATION . . .

(Continued from page 569)

(c) the right to freedom of religion,
(d) the right of parents to bring up their children as they deem best, and
(e) the right of property, specifically the right to the same type and quality of water in one's plumbing system as was available when it was first installed.

COURT HOLDS FIRM

The court turned these arguments back at every point.

The key issue in the case was whether caries is a public health problem and a proper subject for public health legislation. The court held that it was, though conceding that it was also a private problem.

In so holding, the court was not unaware that legislation to be constitutional must be for the general welfare, and not for the benefit of individuals or special classes only. The conservative form of this general welfare doctrine is more clearly stated in the negative: Legislation is invalid if the harm it seeks to eradicate is a private rather than a public harm.

Health laws designed to keep Jones' infection from spreading to Smith offer no problem even from the conservative view. But the *Froncek* case involved a health law designed to protect Jones and Smith and their children from tooth decay, a non-contagious disease. If the Smiths have a tooth decay problem, they have it as individuals and not from contact with the Joneses in their common society.

So stated, the argument against fluoridation would at first appear to have the better of it under the general welfare doctrine of valid legislation. But the court observed that fluoridation is most beneficial for combating caries in young children and that

"'. . . *the protection thus given will continue well into adult life . . . Children of today are adult citizens of tomorrow, upon whose shoulders will fall the responsibilities and duties of maintaining our government and society. Any legislation, therefore, which will better equip them, by retarding or reducing the prevalence of disease, is of great importance and beneficial to all citizens. In our opinion the legislation does bear a reasonable relation to public health.*'"[2]

Mr. John P. Desmond

Whether this language, quoted by Wisconsin's Chief Justice (Edward J.) Fairchild from the earlier opinion of a Louisiana Court,[3] is consistent with, a modification of, or a breaking from, the more conservative view of the general welfare doctrine is for each to decide for himself according to his personal political philosophy. But whatever political philosophy the quotation represents, it would justify preventive medicine and dentistry under public auspices on a broad scale, at least where children are involved.

Having decided the key issue in favor of fluoridation, the court had little difficulty with the other issues raised by the citizens' group.

NOT AN UNLAWFUL INVASION

Perhaps the treatment of dental caries through medication administered by a city water department on a prescription written by a city council does constitute a municipal practice of medicine, dentistry or pharmacy. But if caries is a public problem, this practice is no more an unlawful invasion of private professional practice than the chlorination of water to prevent the spread of typhoid and other similar contagious diseases.

Perhaps, too, fluoridation narrows the scope for the exercise of private rights and liberties, especially when one considers that the use of the public water supply is a practical necessity for most of us. If our religion prohibits the use of medicines, if we would guard our children against medical or dental treatment as against sin, if we would protect our plumbing against our personal idea of contamination, then fluoridated public water forces us to compromise with our consciences or face the expense of buying bottled water or the inconvenience of digging our own wells.

But courts have never viewed the constitutional guaranties of private rights as guaranteeing their unrestrained exercise. If a reasonable public measure, reasonably designed to promote a genuine public interest, incidentally decreases our opportunities to do as we like or as we feel obliged in conscience to do, courts will not use our private discomfort as a ground for declaring the public measure invalid. Nor did the court in the *Froncek* case hold fluoridation invalid for narrowing the range for the play of our liberties.

The court recognized that the use of the public as a subject for experiment would be an invalid attempt to abuse the legislative power, but it could not concede that experiment was the actual purpose of the fluoridation ordinance. In the court's review of this evidence there was found an abundance of support for the reasonableness of the City Council in adopting the ordinance to diminish the incidence of dental caries among the public and in believing that it would work.

DECISION IS RIGID

The decision on this factual aspect of the case makes it now virtually impossible for anyone hereafter to attack fluoridation in Wisconsin courts again. The court explained that legislative bodies are not required to find the best pos-

(Continued on page 571)

THE EXPERT . . .

Mr. Desmond, author of the accompanying article on fluoridation, is associated with the Madison law firm of Murphy, Gavin and Stolper, and serves as a counsel for the Wisconsin State Dental Society.

[2] 269 Wis. 276 at 284.
[3] *Chapman vs. Shreveport,* 225 La. 859, 74 So. 2d 142.

AMA Groups Initiate Professional Liability Study, to Report in December

Chicago, Nov. 21 — A progress report on a study of professional liability insurance, conducted by the AMA Council on Medical Service, appeared in a recent edition of the Journal of the American Medical Association.

An interim report will be submitted to the AMA Board of Trustees in December.

The Association's Law Department, together with the Council, the AMA Board Trustees and the House of Delegates, initiated the survey. Questionnaires went out this fall to each state insurance commissioner to determine the names of the firms writing professional liability insurance and to ascertain state statutes and regulations that might affect this type of coverage.

In addition, state medical societies were asked to detail experiences they have had with group professional liability insurance coverage and claims prevention programs.

When all the information is assembled, the report stated, it will be possible to analyze, evaluate and compare existing claims prevention programs, procedures for handling complaints prior to litigation and results of litigation by states during the past five to 10 years.

INFORMATION SOUGHT

Information relative to rate increases and variations, reasons for such changes, differences in claims settlement policies and existence of claims prevention programs, as well as opinion of insurance officials as to future trends and desirable corrective measures, should be obtained.

It is anticipated the complete report will require another year's work. The goal is an exact, current and national picture of the causes of claims and availability and cost of this insurance. More important, the report added, it is believed this data will make it possible to determine causes for the present situation and why the problem is aggravated in certain areas.

It is hoped to formulate, thereafter, a long-range educational program for presentation to both medical and legal professions.

Your contribution to the SMS's Charitable, Educational and Scientific Foundation Inc. is always welcome and is a meaningful one.

FLUORIDATION . . .

(Continued from page 570)

sible means of accomplishing valid legislative objectives. Means reasonably adapted to the ends are enough.

Moreover, the court will always presume that the legislative body made a reasonable choice until the person attacking the legislation has carried the burden of proving that the means chosen were unreasonable. That is a difficult burden to carry in almost any case.

In the *Froncek* case, the scientific evidence made the burden of the citizens' group overwhelming. For them to prove the ordinance passed by the Milwaukee City Council unreasonable, they would have had to prove two things. First they would have had to prove that the scientific evidence was downright incredible and impossible for reasonable minds to entertain. Having accomplished that hopeless task, they would then have had to prove that there is a complete lack of any credible evidence in support of fluoridation in any other quarter. A failure of proof on either point would preserve the presumption that the City Council had chosen a reasonable means to the end sought.

It is not at all likely that the Wisconsin Supreme Court will reverse itself on the proposition that a disease so prevalent as dental caries is a proper object for public health legislation. That is a proposition of law, and appellate courts, once they take a stand on the law, do not easily change their minds. On a proposition of fact, such as "fluoridated water tends to prevent caries," courts are always willing to review new evidence such as may be brought forward in later cases.

But after the Froncek case, it is now apparent that the enemies of fluoridation should expect no success in Wisconsin courts until they first do battle on the scientific front and score a rout.

DR. E. R. LOFTUS NAMED STATESAN DIRECTOR

Madison, Nov. 21—The new superintendent and medical director of the State Tuberculosis Sanatorium at Wales (Waukesha County) is Dr. Edward R. Loftus of Manchester, N. H.

Appointed by the State Board of Health, Dr. Loftus succeeds Dr. Ellison White who resigned this fall to accept a similar post in Texas.

A graduate of Middlebury (Vt.) College, the new director obtained his medical degree from Albany (N. Y.) Medical College. He served with the U. S. Army Medical Corps from February, 1953, to February, 1955, as chief of chest diseases at Ft. McClellan, Ala. Since his discharge, he has been engaged in private practice.

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MUNICH DOCTOR OFFERS VIEWS ON U. S. MEDICINE

Makes Comparisons on Nurses, Insurance, Status of MDs

Madison, Dec. 1—A young Munich doctor, serving an internship here, expressed his impressions of American medicine in a letter to the Society this week.

Dr. Walter Eichlseder, who was graduated in 1952 from the University of Munich, and received post-graduate medical education in Zurich, Paris and Munich, currently is serving at St. Mary's Hospital, working under the guidance of Dr. Charles B. Larkin, resident.

The visitor from Germany said his impressions were obtained from St. Mary's only, and that he has not had an opportunity to visit an American school of medicine or other hospitals, which he intends to do before returning to his native land.

In his own words, here are his reactions and views re medicine in America:

. . . ON NURSING

"The nursing care and the training of the nurses, which is not only a professional instruction, but at least in our hospital (St. Mary's) —also personal education, is excellent. Bedside clinical notes are unknown in Germany. They really require the nurse to occupy herself with each patient. The full number equipped night service provides a better nursing care than only 1-2 night-nurses in Germany. Only the overfeeding of the nurses with too much theoretic medicine is in my opinion—although acknowledging the necessity to teach them a fundamental conception of medicine—an overload of their learning capacity and builds up a dangerous half-knowledge.

"And, in spite of this knowledge, even the graduate nurse who sees the patient all day and thus knows his peculiarities much better, has to ask the doctor for a simple sleeping pill, Empirin or an enema; whereas this is done in our country, based on the judgment of an older nurse—unless it is very difficult case—and never anything adverse has happened.

"Reading the medical literature, I see that the research work, not only the experimental studies, but also the evaluation of clinical results, is done with a broadmindedness and a generosity which should be a model for us. This is a consequence of having a good economic standard and the willingness to interchange professional advancements. A good example of this farsighted scientific work and absolutely worthy of imitation, is the excellently run rheumatic fever clinic. The literature itself, especially the great textbooks with their good system of dividing the topics with eminent physicians as contributors, impresses me by the very cautious and precise manner of presentation.

Dr. Walter Eichlseder

A FORUM FEATURE

"There is the importance of the family doctor here, the large esteem he enjoys, that is quite different from Germany, where very often the patient himself decides, to which specialist he has to go without having seen any general practitioner. The very large percentage of private hospitals is another fact to an uninterrupted wholesome personal relation between the physician and the patient, and of the greatest value for both, insofar as the family doctor continues the therapy and does not relinquish the patient.

. . . ON HOSPITALS

"The supervision of the hospital by the Joint Commission on Accreditation of Hospitals is a very good idea with regard to hospitals with a medical director, providing the desired level of hospital standards. But it seems to me to degrade the chief of staff, whether he is a professor of medicine or another experienced physician, in that his work has to be submitted to the yearly approval of such a commission, where really his personality, once approved, guarantees the solidity of his institution.

"The fact that insurance does not pay all costs, whereas in Germany a great deal of insurances pay the whole stay in the hospital including all costs, has many good sequelae: 1) the patient is able to better estimate the doctor's work; 2) the patient wants to get healthy as soon as possible, and to be a malinger only for (a) little vacation is too expensive; 3) the physician is able to use all diagnostic and therapeutic methods he estimates as the best, (while) in Germany the physician must ask the insurance company, when he wants to use modern methods.

"The greatest impression is the cordiality and congenality of the American physician, and the strongly marked and highly developed sense of tolerance, which is not only their quality but in general of Americans as people, which makes the atmosphere in this country very pleasing."

Dr. Eichlseder, who hopes to be a practicing pediatrician or a specialist in rheumatic fever in Germany in the distant future, will remain here at least until June 30, 1956.

Neff Appointed

Reno, Nev.—With the recent appointment of Nelson B. Neff as executive secretary of the Nevada State Medical Association, all 48 states now employ full time secretaries.

Neff visited the State Medical Society of Wisconsin offices in Madison in November, studying the Blue Shield operation, organization procedures, committee activities, public relations and legislative efforts.

U. S. PUBLIC HEALTH SPENDING KEEPS CLIMBING

GOVERNMENT PUTS UP—15¢ OF EVERY $1 SPENT FOR HEALTH PURPOSES

Washington, D. C., Nov. 22—Federal health spending will amount to $2,268,826,576 during the current fiscal period, a 6.4 per cent boost over 1954–55, the Washington AMA office reported.

This figure is 15 times the amount needed to maintain Congress and the federal courts, 14 times the total budget of the State Department, and four times more than is spent by either the Labor Department or the Post Office Department.

Expressed another way—

Uncle Sam puts up $15 of every $100 spent by the American populace, publicly or otherwise, for health and medical purposes, from purchase of toothpaste to financing cancer research.

The AMA based its factual study on budgets, appropriation bills and information obtained directly from government agencies and departments.

The Department of Health, Education and Welfare expenditures will aggregate $526,935,400, or $127,754,900 more than during the previous year. Only two other agencies' medical spending is over the half billion mark, that of the Defense Department and Veterans' Administration.

HEW is spending 32 per cent more in the health fields, and this is explained largely by sizeable increases in funds for Hill-Burton hospital construction ($88,800,000, up 13.8 million); for vocational rehabilitation ($36,825,000, up 8 million), and by a $30,000,000 appropriation to buy Salk vaccine and finance inoculation programs.

VETERANS' SPENDING

A total of $615,869,000 was allocated for in-patient care in 173 VA hospitals. This is a hike of 48 million, and provides for an average of 120,873 beds daily. The current load is 106,682 beds, just under 90 per cent of capacity.

Funds for out-patient care in 99 VA clinics were reported at $66,509,000. The report also said $7,861,000 was earmarked for fees to physicians doing home-town care work and $11,100,000 for dentists under the same program.

A new program of medical facilities began with a grant of 21 million dollars. This will be used for construction of hospitals for the chronically ill and impaired, diagnostic centers, nursing homes and rehabilitation facilities.

Indian Health Activities was allocated $38,840,000, now under HEW direction instead of the Interior Department. The Children's Bureau allotment was boosted from $31,600,000 to $35,796,600, and the Food and Drug Administration budget from $5,202,000 to $6,266,000.

MEDICAL-HEALTH BUDGETS OF FEDERAL DEPARTMENTS, AGENCIES AND COMMISSIONS FOR THIS FISCAL YEAR

Agency	*Fiscal 1956*	*Fiscal 1955*
Department of Defense	$818,104,500	$844,087,500
Veterans Administration	790,185,800	754,819,344
Department of Health, Education and Welfare	526,935,400	399,180,500
Federal Civil Defense Administration	30,450,000	28,755,000
Atomic Energy Commission	27,700,000	26,800,000
International Cooperation Administration	25,441,000	31,137,900
Department of State	13,669,790	12,607,667
Department of Labor	7,336,000	7,171,857
Federal Employees Health Program	6,000,000	6,000,000
Department of Interior	5,770,000	5,837,909
Panama Canal Zone	5,702,900	5,800,503
National Science Foundation	5,000,000	3,600,000
Department of Treasury	2,990,000	2,770,000
Department of Justice	1,470,000	1,277,362
Federal Trade Commission	1,000,000	1,000,000
Civil Service Commission	382,600	350,000
Department of Commerce	277,586	299,733
National Advisory Committee to Selective Service	180,000	147,444
President's Committee for Handicapped	130,000	87,653
Health Resources Advisory Committee	101,000	90,000
Totals	$2,268,826,576	$2,131,820,372

Help Fight TB

Buy Christmas Seals

S.S. Commissioner Speaks On Old Age, Survivors' Insurance Future

Baltimore, Nov. 28—Charles Schottland, Social Security Commissioner, told the Gerontological Society that by 1980 almost all retired aged will be eligible for Old Age and Survivors' Insurance.

He also said social security payments now are going to about half of the nation's aged population.

"With real progress being made toward solving the income problems of the aged, it's now possible to give greater consideration to paying for medical care," Schottland said.

In his view, some of the avenues that might be explored: (1) extension of Blue Cross and other insurance arrangements to nursing home care; (2) development of home nursing services and (3) use of plant health facilities of former employers.

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NO SURPRISE: PHARMACISTS STIRRED BY AMA DRUG-DISPENSING RESOLUTION

Madison, Nov. 22—The resolution adopted at the AMA convention last June relating to dispensing by physicians has aroused much controversy—as expected—among pharmaceutical groups.

The House of Delegates voted unanimously to delete a confusing and ambiguous section (Chapter 1) of the Principles of Ethics which made ownership of a drug store and dispensing by physicians unethical, and to substitute a new Section 8 which states:

> *"It is not unethical for a physician to prescribe or supply drugs, remedies or appliances, as long as there is no exploitation of the patient."*

At the AMA convention in 1954, delegates from the State Medical Society of Wisconsin were almost alone in opposing unsuccessfully adoption of the section which won great support last summer.

Norbert E. Beck, president of the Wisconsin Pharmaceutical Association, wrote in his message in *The Wisconsin Druggist* recently:

> **"The AMA . . . has once again shown an utter disregard for any other kindred organization. It becomes apparent that something slipped by the convention assemblage. Was this truly the wish of the majority of the AMA membership? I do not think so.**
>
> **"It is entirely possible this problem will be corrected within the next year to two."**

"RABBIT PUNCH"

In Pharmacy and Science News, a featured section of *Drug Topics*, one writer, Louis E. Kazin, termed it a "rabbit punch" to interprofessional progress between pharmacy and medicine. Kazin continued:

> **"If we interpret this correctly, it would appear this House of Delegates has undone years of combined interprofessional effort.**
>
> **"The AMA has turned back the clock. This has provided an 'open sesame' to those in the medical profession who wish to practice both medicine and pharmacy.**
>
> **"The only thing we can conclude is that the AMA just 'doesn't give a hang' over the continued perpetuation of friendly relations with pharmacy and this is their way of saying it.**
>
> **"This is glaringly inconsistent."**

The Rhode Island Pharmaceutical Association at its summer convention adopted a resolution asking the AMA to rescind its action and not to interrupt the "pleasant, cooperative' relationship now existing between medical and pharmaceutical professions.

Wholesale druggists also expressed "profound disappointment" at the change, and warned it "is likely to prove highly detrimental to both medicine and pharmacy should the occasion again arise when it becomes necessary to present a unified front in opposition to congressional legislation aimed at socializing medical services".

AMEF APPEALS FOR MEDICAL TEACHING FUNDS

Chicago, Nov. 20—The American Medical Education Foundation appealed to all AMA members this month for contributions to reach a 1955 goal of $2,000,000.

A special appeal, signed by Dr. Elmer Hess, Erie, Pa., AMA president, asked for pledges to continue a program of financial aid to the nation's medical schools.

John Hedback, acting executive secretary of the Foundation, said:

> **"With the wholehearted support of every member of the medical profession, the Foundation can achieve its annual $2,000,000 goal and maintain high medical teaching standards without federal subsidies.**
>
> **"At no time has the need been so great for individual financial support."**

During the first nine months of this year, contributions amounted to $549,343, compared with $996,-199 during a corresponding period in 1954. This year's figure included an AMA grant of $100,000.

Dr. Hess' letter included a folder which stressed the importance of tax savings by contributing immediately to the Foundation.

LEGION ACTS ON MEDICAL MATTERS

Miami, Fla., Nov. 14—The American Legion, at its national convention here, took these actions:

Reaffirmed its policy in support of VA medical care and hospitalization for non-service-connected cases.

Rejected Congressional legislation authorizing recognition of chiropractic by VA's medical department.

Rejected extension of time for presumptive service-connected of all physical and mental disabilities.

AMA Trustee David Allman, Atlantic City, N. J., addressed the convention, soliciting Legion aid in battling permanent and total disability insurance and demanding passage of the Bricker resolution.

The Executive Committee of the National Rehabilitation Commission perfunctorily adopted a resolution endorsing maintenance of medico-political relations with AMA to explore policies which may be determined to be benficial to the aims and ideals of both organizations (Legion and AMA)."

VA Administrator Harvey A. Higley disclosed plans are being advanced for replacing 12 outmoded veterans' hospitals.

Doctors, Others Asked To Destroy Abandoned Refrigerators, Iceboxes

Wausau, Dec. 1—The Employers Mutual Liability Insurance Co. of Wisconsin, accident prevention division, has called on physicians and other community leaders to destroy or render harmless abandoned refrigerator and icebox units.

The division said nearly 100 youngsters have suffocated in the units since 1948, and that there appeared to be little letup in deaths caused by this threat.

F. W. Braun, vice president of the division, urged:

"Help talk up precautions in your community . . put them into effect if they apply to your operations . . . do whatever you can to protect our 'small fry' from this particular threat."

He asked adults to remove doors of the abandoned or unused boxes, to drill holes in the cabinets, remove latch stops, or to smash the units.

Announce Plans for Survey of State Epileptic Problems

Madison, Nov. 25—The Rehabilitation Division of the State Board of Vocational and Adult Education will undertake a survey of the epilepsy problem in the near future.

The study will attempt to verify the number of epileptics in Wisconsin, now estimated at 14,000. The social, personal and economic data secured will be utilized to develop effective techniques in rehabilitation efforts.

John A. Kubiak, Division chief, commented:

". . . The present program is lacking in effectiveness. An objective study is needed to indicate the exact strengths and weaknesses."

The Division reported seizure control in 85 to 90 per cent of its epileptic clients, but that the job of total rehabilitation is being accomplished in only 25 per cent because of such factors as lack of acceptance by employers, schools and society in general.

The study will concern itself mainly with the epileptics' economic status and job records. Such matters as regulations, prejudices, attitudes and beliefs also will be surveyed.

Dr. Edward D. Schwade, Milwaukee neuropsychiatrist and an authority on epilepsy, will serve as consultant during the study.

Health Care, Fees And Patient Rating Reprints Available

Madison, Nov. 28—Pamphlets and reprints of articles of interest to the medical profession are available through the offices of the State Medical Society.

Subjects available include:

1. Free Health Care for Everyone?—prepared by the U.S. Chamber of Commerce—presents useful information involving economics of our nation's health;

2. Do Doctors Charge Too Much?—from the May, 1955, *Coronet* magazine—discusses medical care in the light that today's medical bills are not out of line with prices paid for other consumer commodities, and

3. Do You Make Par as a Patient?—from *Family Week* magazine, Sept. 11, 1955.

ON THE SMS CALENDAR . . .

December

7—Claims Committee, SMS.
8—Open House for Milwaukee County Society Staff, SMS.
10—Commission on Prepaid Plans, SMS.
10–11—Midwest Medical Conference, SMS.
12–16—Health Tour with Board of Health, Albany, N. Y., and Richmond, Va.
17—Maternal Mortality Study Committee, Milwaukee.
25—Merry Christmas!
29–30—State Board of Health, SMS.

January

1—Happy New Year!
3—Claims Committee, SMS.
5—Wisconsin Public Health Council, SMS.
7–8—Joint Meeting of Audit and Budget and Executive Committees, SMS.
10—Public Policy Committee with Staff Board of Medical Examiners, SMS.
13–14—Clinic Managers, SMS.
17—Postgraduate Clinic, Richland Center.
17—Mid-year Auxiliary Conference, Milwaukee.
18—Postgraduate Clinic, Oconomowoc.
19—Postgraduate clinic, Sheboygan.
28—Interprofessional Institute, SMS.

February

7—Claims Committee, SMS.
14—Postgraduate Clinic, Janesville.
15—Postgraduate Clinic, Stevens Point.
16—Postgraduate Clinic, Green Bay.

HERE'S A TIP! ORDER "TO ALL MY PATIENTS"

Chicago, Nov. 25—A leaflet, To All My Patients, designed by the AMA as a public relations aid for doctors to make a hit with their patients, is now available.

Prepared for MD's to distribute to their clients in an effort to foster better doctor-patient relationships, the 12-page booklet briefly discusses various aspects of medical care services, fees and health insurance.

Space has been left on the back cover for the doctor to insert his name and office address.

Physicians desiring to order copies are asked to fill out the coupon on this page.

To All My Patients begins:

"I appreciate the confidence you have expressed in me by selecting me as your physician. I sincerely hope that I can give you and your family the kind of medical service you desire . . ."

The leaflet concludes:

"It is difficult for a physician briefly to explain every service necessary in providing good care because each case is different. I sincerely hope this leaflet will give you a better understanding of some of the services you may require."

An office plaque, a companion public relations aid, on which patients are invited to discuss freely any questions relating to fees or services, also is available at $1.

Remember—you are welcome to visit the new home of the State Medical Society of Wisconsin in Madison anytime!

Listen to the "March of Medicine" on any one of 42 Wisconsin radio stations every week.

State Medical Society of Wisconsin
Public Information Div.
P. O. Box 1109
Madison, Wisconsin

Send me _____ **To All My Patients** pamphlets (without cost)

Also send _____ office plaques at $1 each.

Name _____

Address _____

City _____ State _____

(Please Print)

Changes in School–Physician Relations Proposed at School Health Conference

Madison, Nov. 25—Wisconsin was well represented at the Fifth Annual Conference on School Health at Highland Park last month.

Dr. E. H. Pawsat, Fond du Lac, chairman of the Division on School Health of the Commission on State Departments, and Roy T. Ragatz, assistant secretary, attended representing the State Medical Society.

The AMA conference emphasized the importance of having all school children's health examinations conducted by the child's own personal physician in the doctor's office.

In addition, there was great stress on the necessity for an interchange of medical information about pupils between the personal physician and the school. One of the important steps in this program would be to make the physician or the county medical society a part of the local school health council.

It was pointed out that the physician must know the attitude of the local county medical society in relation to the school health program before he commits himself to policies concerning it. The school should go through "channels" and not go directly to an individual M.D. for help.

MORE WORK NEEDED

There must be increased efforts to have physicians understand more fully the functions of the school and also that school personnel understand the ethics of the medical profession in reference to the transmission of medical information concerning a child's health. Some attending the conference stressed the necessity for physicians transmitting information only with the permission of the parent. Most agreed that medical information should be handled with extreme care and transmitted from the personal physician to the school physician or the school nurse rather than to teachers and school authorities.

In any event, all medical information transmitted in writing to school authorities should be kept under lock and key.

COMPLETENESS ESSENTIAL

Concerning school health examinations, it was emphasized that the completeness and adequacy of the examination was far more important than the uniformity of the reporting forms. In respect to adequacy, it was pointed out that a proper examination can be conducted only when the child is undressed.

Since full-time school physicians are pretty much outmoded, school and physician representatives at the conference were advised to have part-time physicians serving schools on a rotation basis. Many communities have worked this out in direct cooperation with the county medical society.

"HALO" PACKS PUNCH, HUMOR

Madison, Nov. 29—On this page is the *Medical Forum's* second cartoon from *Is Your Halo on Straight?*, a booklet published by the San Lucas Press of Los Angeles.

Last month's cartoon showed the MD under a microscope, with the public viewing the process.

This month's cartoon shows "The Ghost," a rapier-thrust at the physician who uses second-hand diagnoses and post-mortem platitudes.

Much interest has been evoked by *Halo* because of its pointed treatment of certain conditions which could exist in the medical profession.

During the coming months, the *Forum* will reprint cartoons from the booklet. Full of wit and surprising knowingness, the publication shows little fear of treading on toes.

The Ghost

This wraith rarely sees the patient except inside out. He uses second-hand diagnoses and post-mortem platitudes.

He's a clandestine character who cuts and runs. Uses a two-edged scalpel—one splits the patient, the other splits the fee.

If we don't tar and feather him, somebody else will—and a lot of it will be splashed on us.

"I don't believe we've met before...."

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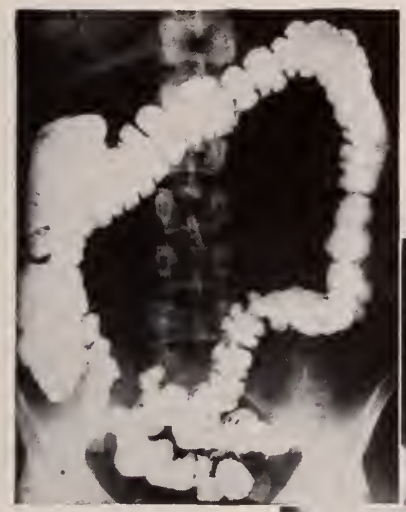

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Atonic Colon

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Volume 54 NOVEMBER 1955 Number 11

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A Little Learning*

A little learning is a dang'rous thing;
Drink deep, or taste not the Pierian spring:
There shallow draughts intoxicate the brain,
And drinking largely sobers us again.

Alexander Pope probably was not thinking about the unauthorized practice of law when he penned these lines, but he might have been. What lawyer has not encountered the layman who has had frequent occasion to come in contact with a certain branch of the law, who has learned to look up case and statute citations, and who is so sure that he knows more about it than any lawyer of his acquaintance that he is eager to argue and to demonstrate his proficiency?

The main reason why a non-lawyer may not safely be trusted with another person's problems, even in the one field which is his specialty, is that no way has ever been found to departmentalize the law so that the various fields do not overlap. Real estate law is inextricably bound up with the law of wills and estates, with trust law, and with many other branches of the law. Legal scholars express this concept by speaking of the law as a "seamless web." Only a person equipped to survey and deal with the law in its entirety is safe to be trusted with any legal problem.

* Reprinted by permission from the February–April, 1955, *Journal of the American Judicature Society.*

(continued in column 1, page 34)

Res Ipsa Loquitur

When it is obvious to anyone just who is responsible for an injury, it isn't necessary, we understand, to prove it in court. If a brick falls on your head as you leave the hospital and that brick fits precisely in a hole in the cornice, it's pretty clear that's where the brick came from. The judge won't ask for hours of testimony to prove the fault. Our colleagues in the legal profession call the doctrine "*Res Ipsa Loquitur*"—the thing speaks for itself.

In the adjoining editorial, the American Judicature Society, a distinguished arm of the legal profession, warns against the attempted inroads of the untrained, the incompetent, and the uneducated into the practice of law. It need not belabor the serious public consequences which would follow were such attempts successful. Each of us in the medical profession can point to scores of tragedies resulting from the incompetence and the culpable fraud of the quack and the cultist. We are well aware of the importance of professional training in the fields of law and medicine—the thing speaks for itself.

The adjoining editorial raises several questions in our minds, however; and we don't believe *Res Ipsa Loquitur* is going to be helpful.

We notice in the editorial that the American Judicature Society calls upon every lawyer to oppose certain legislation before the Congress. This legislation, allegedly, would permit unqualified persons

(continued in column 2, page 34)

(continued from column 1, page 33)

This is not to say, of course, that some good legal advice has not been given by non-lawyers in the course of what the profession speaks of as the unauthorized practice of law. But only a physician or surgeon fully equipped by education and training is safe to be trusted with the health of our children, and that is true in spite of the fact that wonderful cures have been wrought by others.

A very similar case may be made for a broad general education for the lawyer. Not only is the law a seamless web—so also is all human knowledge and experience. When a client walks into a lawyer's office, the lawyer is entitled to suppose that there is some legal problem to be solved, but he never knows but what he will also have to draw upon his knowledge of economics, psychology, anatomy, history, chemistry or astronomy. That is why a person ignorant of all but the three R's might possibly absorb enough Blackstone to pass a bar examination, but would still be ill fitted to practice law.

We have been led to ponder these things as we have contemplated with disquietude the proposals now before Congress and the Treasury Department to give official sanction to the doing by non-lawyers of certain things that are the very essence of practicing law.

One proposal is to modify Section 10.2 (f) of Treasury Circular 230 to eliminate the provision that "nothing in the regulations shall be construed as authorizing persons not members of the bar to practice law." The other is a bill first introduced as H.R. 9922 last year and re-introduced this year as H.R. 1601 and H.R. 2461, providing that "the Secretary of the Treasury shall by regulations prescribe, to the extent that he considers practicable and desirable, qualifications, rules of practice and standards of ethical conduct, applicable to persons who assist taxpayers in determination of their federal tax liabilities, in preparation of their federal tax returns, and in settlement of their federal tax liabilities with the Internal Revenue Service: Provided, that no person shall be denied the right to engage in such activities solely because he is not a member of any particular profession or calling."

The danger is three-fold. In the first place, although in many instances the services would be performed adequately, there would be many instances to the contrary, for unauthorized practice is not a mere bogey invented by lawyers to forestall competition, but a very real menace to the public. Secondly, it would set a precedent that would, if followed, all but destroy the boundaries of law practice. If lay specialist A is to be permitted to do the equivalent of practicing law in his particular field, then why not B, C, D, E, F, X, Y and Z? What branch of law will be safe from the encroachment of *some* lay specialist? If the accountant today, then why not the trust officer tomorrow, and the real estate broker and the social worker the next day?

(continued in column 1, page 35)

(continued from column 2, page 33)

to practice law before federal agencies and courts. We will not only predict, but we will wager that, come the Congressional hearings, the legal profession will stand alone in opposition. As a reward for its diligence and dedication to the public interest, it will be charged with muzzling competition and pure selfishness. We of the medical profession know this from long and bitter experience in safeguarding the public health.

Why must the legal profession stand alone and why must we? Isn't it the obligation of all professional people to train and educate first and then to combat ignorance and incompetence wherever we find it? Isn't it our duty, in the public interest, to join together in the common cause?

We are mightily concerned that the medical profession is expected to combat singlehandedly the diversified legislative and legal campaigns of the naturopaths, the chiropractors, the coloropaths, the physiotherapists, the uranium tunnel operators, the faith healers, the naprapaths, and a score of other cultist and quack groups. They are becoming increasingly more arrogant and powerful. This is an awesome responsibility the medical profession has been given, and it needs help. We know that is true of the legal profession as well.

Where are the other professional groups we would naturally expect to help guard public health interests? The pharmacy association, for example—the rank and file of its working members excepted—is engaged in an indefatigable effort to outlaw clinic pharmacies, to permit drugs to be dispensed only in drugstores, and to add indefinitely to the list of drugs which must be prescribed. So far as we have been able to observe, that effort has consumed the major portion of the association's time. The pharmacists who by training and education know the therapeutic value of drugs have yet to be heard by us in legislative or legal opposition to the fantastic propositions of the chiropractors and naturopaths—the self-acclaimed drugless healers. Even those callous enough to suggest that the leadership of the Wisconsin Pharmaceutical Association is motivated in its present efforts more through economic than altruistic principles might wonder why it failed to inform the legislatures and the courts of the fallacy in drugless healing as an exclusive theory. Its voice would be helpful, respected, and welcome.

We remember the last legislative antivivisection fight, as we're sure you do. The proponents, of course, would have prohibited the use of animals for research and teaching purposes. The proponents ranged from Irene Castle McLaughlin to one of the political leaders in this state or vice versa. The opposition was the medical profession—period. It was outnumbered 20 to 1, and that is important in the legislature.

(continued in column 2, page 35)

(continued from column 1, page 34)

Finally, we are concerned about the implications of the proposed rules and laws with respect to future regulation of unauthorized practice and bar admission. We do not for a minute accept the idea that a bill which merely says that membership in a particular profession is not to be a prerequisite to the rendering of certain services in connection with the federal income tax is a strong enough peg upon which to hang the proposition that Congress is thereby completely preempting the field of regulating the practice of law. But it is surely a peg of some sort, and we may be certain that if it is passed, as much will be hung on it as it will hold, and that it will be the forerunner of others. Every lawyer who is truly interested, not only in his profession but also in the public which his profession exists to serve, will do what he can to oppose enactment of this legislation.

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(continued from column 2, page 34)

Let us suggest that you put this to one of your friends in the legal profession. If he's like our friend, he'll smile, condescendingly, and tell you that antivivisection is ridiculous and that everyone knows it would stifle medical, pharmaceutical, and scientific advances. After he has condescended long enough to suit you, shock him with this. Tell him that the medical profession won that battle, after a filibuster, with *one single* vote. Urge him, as a person trained to recognize truth, to join with us in the fight against ignorance and intolerance.

Antifluoridation is the current rallying ground of the chiropractor. Whether it's antifluoridation, antivaccination, or whatever, he is always antimedical and antiscientific. The success of the chiropractic efforts can currently be observed in the defeat of municipal fluoridation referenda throughout the state. With the primary effort of the dental profession and an assist from the medical profession, the cultists' effort to hamper the Board of Health in its fluoridation program was defeated. The odds were about 30 to 1 against us. We were lucky.

We remember an editorial a long time ago entitled "Afghanistanism." Its point was that we each lived in a little island of isolation and were concerned only with those problems which faced us individually. Even if we treated them justly and idealistically, we weren't doing our job. It was our own obligation, in the interest of ourselves and the public as a whole, to band together in the common good.

We allude to the American Judicature Society editorial for the last time. If we can assume the accuracy of its statement that the Congress considers permitting untrained and incompetent persons to practice law, then we suggest to the Society that it sound its warning not only to the lawyers in its group but to all public-spirited persons, regardless of their profession or calling, as well. It is not too late to join hands.

So far as the public health is concerned, it is high time that the medical profession be permitted to abandon its "Horatio at the Bridge" role. So long as the people can be duped by the cancer quack and dazzled by the cultist and quack, every thinking person must do battle against them. Think of the countless organizations and groups organized in a myriad of health interests. The medical profession could so easily share its responsibilities with them. Properly directed, they could be an irresistible influence in the broad public interest. It is our job to educate, to direct, and to interest the thinking elements in the cause.

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Society Proceedings

Ashland–Bayfield–Iron

Dr. Jules Chase of Milwaukee was the guest speaker at the September 22 meeting of the Ashland–Bayfield–Iron County Medical Society at St. Joseph's Hospital, Ashland. He spoke on "The Diagnosis and Treatment of Congenital Heart Disease."

A discussion was held on the status of poliomyelitis and concerning the Pureair Sanatorium at Bayfield.

Fifteen members of the society were present.

Brown–Kewaunee–Door

The October meeting of the Brown–Kewaunee–Door County Medical Society was held on October 13 at the Elks Club, Green Bay. Program chairman was *Dr. John Dettmann* of Green Bay.

The 52 members who attended heard the following guest speakers from Marshfield: *Dr. John Suits*, pediatrician, who discussed "The Immunology and Treatment of Erythroblastosis"; *Dr. George Magnin*, internist, who spoke on "Bronchiectasis"; and *Dr. Ben Lawton*, thoracic surgeon, who discussed "Cardiac Arrest."

Clark

Election of officers was held at the September 29 meeting of the Clark County Medical Society at the Hotel Colby, Colby.

Physicians elected to office were:

President—*Dr. J. W. Koch*, Colby
Secretary–Treasurer—Dr. T. N. Thompson, Neillsville
Delegate—*Dr. M. V. Overman*, Neillsville
Alternate Delegate—*Dr. R. L. Hansen*, Colby

Dr. Arthur Macht of Marshfield addressed the group following the business meeting.

Dane

The Dane County Medical Society held its annual meeting on October 11 at the Madison Club, Madison, at which time the following officers were elected for the new year.

President-Elect—*Dr. J. E. Nordby*, Madison
Vice-President—*Dr. R. J. Hennen*, Madison
Secretary–Treasurer—*Dr. Thomas V. Geppert*, Madison

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Dr. P. B. Golden, Madison
Dr. E. J. Nordby, Madison

In its business meeting the society heard reports on an audit by the Auditing Committee composed of *Drs. C. O. Vingom* and *J. S. Supernaw* of Madison; the secretary's report presented by *Dr. Thomas V. Geppert;* the president's report presented by *Dr. George Hank*, Madison; and a report of the activities of the Geriatrics Committee, headed by *Dr. George Stebbins* of Madison.

Fond du Lac

Officers elected by the Fond du Lac County Medical Society at its meeting on September 22 at the Elks Club were the following Fond du Lac physicians:

President—*Dr. Josephine N. Pallin*
Vice-President—*Dr. Hugh J. McLane*
Secretary—*Dr. David A. Smith*
Treasurer—*Dr. James C. McCullough*

The members agreed to support the bloodmobile program to be carried out in Fond du Lac from October 4 to 6. They also determined to request the State Board of Health to send its mobile tuberculosis x-ray unit to the community in the spring of 1956.

Dr. Dean Willson of Fond du Lac was named chairman of the society's Civil Defense Committee. An invitation was accepted for the members to meet jointly with the Outagamie County Medical Society on December 15. *Dr. Howard Mauthe* of Fond du Lac was elected as the county society's member of the Board of Trustees of the Charitable, Educational, and Scientific Foundation of the State Medical Society.

There was considerable discussion of the distribution of the poliomyelitis vaccine. A committee consisting of *Drs. H. J. Kief, J. S. Wier, E. H. Pawsat, R. L. Waffle*, and *F. J. Cerny* was appointed to develop recommendations on this matter and present them at the October 27 meeting of the society. During early September an unofficial meeting had been held at which the society determined to restrict the use of poliomyelitis vaccine until after November 1.

The October meeting of the society was held at the Elks Club on October 27.

Dr. Samuel Harper of Madison was the guest speaker and chose as his subject "Hysterectomy vs. the Tissue Committee."

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Grant

The Grant County Medical Society met at the golf club at Lancaster on October 13 for a program starting at 2:30 p.m.

Dr. Ralph Campbell, Madison, discussed "Common Obstetrical Complications"; and *Dr. Robert O'Connor* of Madison spoke on "Child Psychiatry."

A business meeting followed an evening dinner.

Jefferson

Dr. Henry Suckle of Madison was the guest speaker at the meeting of the Jefferson County Medical Society on September 22 in Watertown. His subject was "Important Diagnostic Signs in Neurological Surgery."

Kenosha

When the Kenosha County Medical Society met on October 6 at the Elks Club, Kenosha, Dr. Leonard Krasner of Waukegan, Illinois, was guest speaker. He spoke on "Palliative Treatment of Lung Cancer."

Doctor Krasner is on the staffs of Victory Memorial and St. Theresa hospitals at Waukegan and is consulting thoracic surgeon at the veterans hospitals at Hines and Downey, Illinois.

A county society committee also reported on the Willowbrook Sanatorium. Fifty members attended the meeting.

Manitowoc

Thirty-four members of the Manitowoc County Medical Society met at the Hotel Manitowoc on September 22. Guest speakers were *Drs. Sherburne F. Morgan* of Milwaukee and *Chester Kurtz* of Madison; they discussed "Rheumatic Fever."

A rheumatic fever clinic of the Wisconsin Heart Association was held under the auspices of the county society.

Milwaukee

The regular meeting of the Medical Society of Milwaukee County was held on October 13 at the Athletic Club, Milwaukee.

Speakers were *Dr. F. Jackson Stoddard,* assistant professor of obstetrics and gynecology at Marquette University School of Medicine, Milwaukee; and Dr. Robert S. Hotchkiss, professor and chairman of the Department of Urology of the New York University Postgraduate Medical Schools. They spoke on "Childless Marriage."

Dr. Walter M. Kearns, assistant clinical professor of urology at Marquette University School of Medicine, discussed Doctor Hotchkiss' talk.

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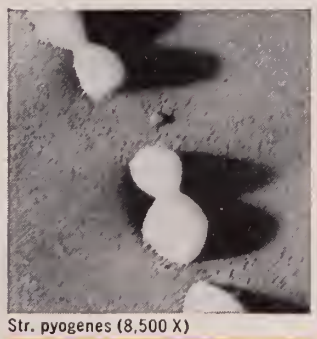
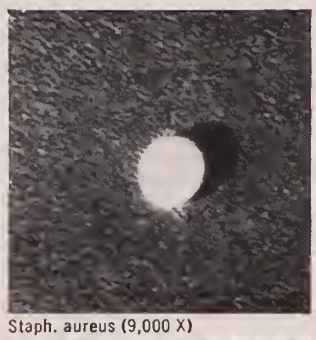
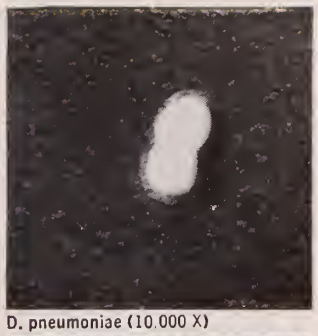
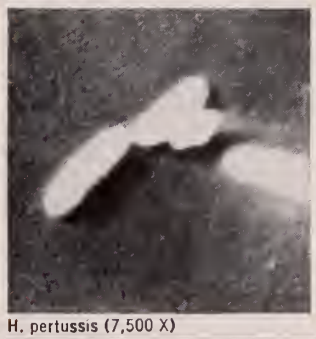

Str. pyogenes (8,500 X)


Staph. aureus (9,000 X)


D. pneumoniae (10,000 X)

K. pneumoniae (13,000 X)

H. influenzae (16,000 X)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Outagamie and Winnebago

"Social Security for Doctors" was discussed by Mr. Robert B. Murphy, legal counsel for the State Medical Society, on October 11 at the Valley Inn in Neenah. Present were members of the Winnebago and Outagamie County Medical societies and dental societies.

Pierce–St. Croix

The monthly meeting of the Pierce-St Croix County Medical Society was held on September 20 at the Steak House in Somerset.

Following dinner, Dr. Frank Babb, orthopedic surgeon from St. Paul, Minnesota, presented a talk on fractures of the leg.

During the business meeting which followed, a new schedule for school immunizations in Pierce and St. Croix counties was discussed and approved.

Racine

The Racine County Medical Society met on October 19 at Rivermoor Country Club, Waterford. Forty-two members were present.

Golf was played during the afternoon. The evening speaker was Mr. Otto Hughlett of Burlington. A short business session was also held.

Sauk

A dinner meeting of the Sauk County Medical Society was held at the Warren Hotel, Baraboo, on October 11. The program was devoted to a discussion of public health.

Seventh Councilor District

Physicians of the Seventh Councilor District met on October 17 at the Fireside Inn, La Crosse.

Dr. A. R. Curreri, Madison, was the guest speaker and discussed "Massive Gastrointestinal Hemorrhage." Mr. Jack Burke, public information executive assistant at the State Medical Society, told about the State Society's new office building and the public relations program of the Society.

Tenth Councilor District

A meeting of the Tenth Councilor District was held at the Hillcrest Country Club, Eau Claire, on September 22. Dr. W. W. Bauer, director of the Bureau of Health Education of the American Medical Association, Chicago, spoke on "Doctors as Citizens" at the evening dinner meeting.

During the afternoon a lecture on fractures in children was presented by *Dr. Walter P. Blount* of Milwaukee, who is president of the American Ortho-

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Surgical Anatomy & Clinical Surgery, Two Weeks, March 5
Surgery of Colon & Rectum, One Week, November 28, February 27
General Surgery, One Week, February 13; Two Weeks, April 23
Basic Principles in General Surgery, Two Weeks, April 9
Gallbladder Surgery, Ten Hours, April 9
Fractures & Traumatic Surgery, Two Weeks, March 12

GYNECOLOGY—Office & Operative Gynecology, Two Weeks, November 28, February 13
Vaginal Approach to Pelvic Surgery, One Week, December 12, February 6

OBSTETRICS—General & Surgical Obstetrics, Two Weeks, February 27

MEDICINE—Internal Medicine, Two Weeks, May 7
Electrocardiography & Heart Disease, Two-Week Basic Course, March 12
Gastroscopy, Forty-Hour Basic Course, March 19
Dermatology, Two Weeks, May 7

RADIOLOGY—Diagnostic X-Ray, Two Weeks, January 9
Clinical Use of Radioactive Iodine, One Week, April 2
Clinical Uses of Radioisotopes, Two Weeks, May 7

PEDIATRICS—Intensive Review Course, Two Weeks, April 9

UROLOGY—Two-Week Course, April 16
Cystoscopy, Ten Days, by appointment

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Lloyd F. Jenk, M. D.
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pedic Society. *Dr. S. A. Morton,* radiologist at Columbia Hospital, Milwaukee, discussed x-ray examinations of the lumbar spine. Surgical treatment of recurrent ventral and inguinal hernia was the topic of Dr. W. H. ReMine of the Mayo Clinic, Rochester, Minnesota. An address on collagen diseases was given by Dr. C. H. Slocumb of the Mayo Clinic.

Milwaukee Academy of Medicine

The Milwaukee Academy of Medicine met at the University Club, Milwaukee, October 18. Dr. Henry M. Lemon of the Department of Medicine, Boston University School of Medicine, Boston, spoke on "A Rational Basis for Endocrine Therapy of Breast Cancer."

A special seminar was held during the afternoon of October 19 at the Marquette University School of Medicine.

Milwaukee Neuro-Psychiatric Society

Speakers at the October 19 meeting of the Milwaukee Neuro-Psychiatric Society were *Dr. H. B. Benjamin;* Clement Fox, Ph.D.; J. Barnard, Ph.D.; and E. W. Bertram, Ph.D., all of the Department of Anatomy of Marquette University School of Medicine.

Their subject was "Some Recent Investigations on the Amygdala."

A business meeting and dinner preceded the evening program.

Wisconsin Radiological Society

The Wisconsin Radiological Society held its annual meeting at Wisconsin Dells on October 7 and 8. The following officers were elected:

President—*Dr. Ralph Frank,* Eau Claire
President-Elect—*Dr. Lester Paul,* Madison
Secretary–Treasurer—*Dr. William W. Moir,* Sheboygan

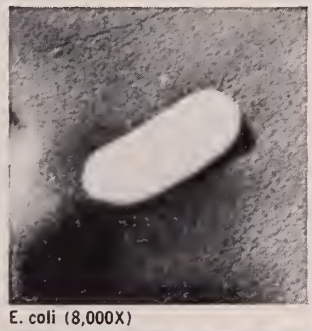
American College of Physicians

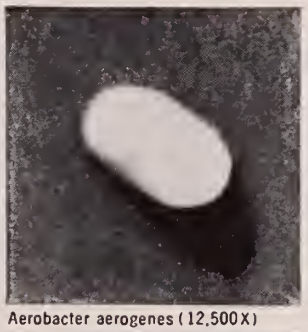
The midwest regional meeting of the American College of Physicians was held at the Wisconsin Union Theater, Madison, on October 15.

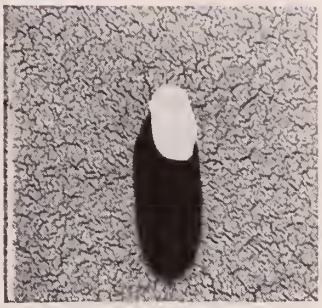
Dr. Karver L. Puestow of Madison, regent of the College, welcomed the group. General chairman of the meeting was *Dr. J. L. Sims,* Madison.

The organisms commonly involved in

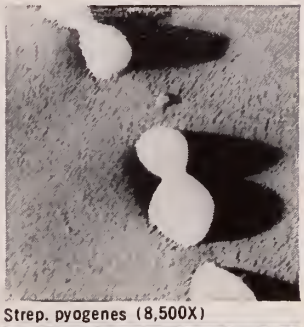
Pyelitis


E. coli (8,000X)


Aerobacter aerogenes (12,500X)


Salmonella paratyphi A (8,000X)

Salmonella paratyphi B (6,500X)


Strep. pyogenes (8,500X)

Strep. faecalis (10,000X)

Strep. viridans (9,000X)

Staph. aureus (9,000X)

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News Items and Personals

Staff Officers Elected at Manitowoc Hospital

At the annual staff meeting of Holy Family Hospital, Manitowoc, *Dr. W. A. Rauch* was elected president of the staff; *Dr. W. H. Scherping*, vice-president; and *Dr. G. M. Simon*, secretary-treasurer. These officers, plus *Drs. R. G. Yost* and *R. G. Strong*, compose the Executive Committee of the staff. All of the physicians practice in Manitowoc.

Doctor and Mrs. Olson in Europe

Dr. and Mrs. *Marvin H. Olson* of Wittenberg spent the month of September in Europe, leaving by plane on September 3. Doctor Olson attended the World Medical Convention at Vienna, Austria, as an official observer of the American Medical Association. They also visited Paris, Munich, Brussels, and other points of interest.

Hudson Clinic in New Building

On Monday, October 3, physicians associated with the Hudson Clinic at Hudson began their practice in a new clinic building which offers greater space and accommodations. Physicians associated with the clinic are *Drs. M. G. Anderson, M. A. Cornwall, G. J. Hopkins*, and *G. E. Bourget.*

Dr. George Boyd on Kaukauna Hospital Board

Dr. George Boyd of Kaukauna was re-elected a member of the Board of Directors of the Kaukauna Community Hospital on October 7. He is president of the board and a member of its executive committee.

Doctor Siefert Speaks to Kiwanians

When the Oconto Falls Kiwanis Club met on October 3, *Dr. C. E. Siefert* of Oconto Falls was the guest speaker. His subject was "Coronary Thrombosis."

Physicians Address Medical Technologists

The Wisconsin Association of Medical Technologists held its fall convention in the Hardware Mutuals Auditorium at Stevens Point on October 8. Speakers on the program and their topics included *Dr. Gerald Fox*, pathologist at St. Michael's Hospi-

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tal, Stevens Point—aspects of endocrinology; *Dr. L. J. Van Hecke,* Milwaukee County Medical examiner—toxicology in the hospital laboratory; Dr. J. A. Venables, assistant pathologist at St. Mary's Hospital, Wausau—a phase of blood banking; and *Dr. H. A. Anderson,* medical director of River Pines Sanatorium, Stevens Point — tuberculosis, current situation and needs.

Dr. H. P. Benn of Stevens Point, president of the Portage County Medical Society, addressed the members at their luncheon.

Dr. James McCullough Talks on First Aid

Dr. James C. McCullough of Fond du Lac spoke to St. Patrick's Holy Name Society on October 3 on the subject "First Aid to First Aids." In his talk he described what and what not to do when there are accidents where persons are injured.

Doctor Rath Honored

Dr. R. R. Rath of Granton was honored September 23 and 24 at the annual Granton Fall Festival. He has administered to the medical needs of that area for a half century.

Dr. T. E. Boston Speaks on Polio

At a meeting of the Women's Civics Club at Hillsboro, September 26, *Dr. T. E. Boston* discussed poliomyelitis, its symptoms and treatment. He also showed slides illustrating the process of manufacturing polio vaccine in commercial laboratories.

Doctor Quick Is Speaker at Interurban Medical Meet

Dr. Armand J. Quick, professor of biochemistry at Marquette University, Milwaukee, was the guest speaker at an Interurban Medical Dinner at the Superior Hotel, Superior, September 21. The group is comprised of physicians from Duluth and Superior.

Dr. Henry Anderson on Panel

Dr. Henry Anderson, medical director of the River Pines Sanatorium, Stevens Point, participated in a panel discussion on "How to Make Our Sanatoriums More Effective," held in Eau Claire on September 24. The session was part of a two-day meeting of the Wisconsin Sanatorium Trustees and Superintendents associations.

Dr. R. G. Welsch Discusses Immunization

Dr. R. G. Welsch of Kenosha led a discussion on "Immunization During Childhood and Infancy" at a recent meeting of the Sheridan Road Parent–Teachers Association. A social hour followed the business meeting.

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THIRD AND TWELFTH DISTRICTS NEWS

Doctor Rosenbaum Speaks at Denver Meet

Dr. F. F. Rosenbaum, Milwaukee, spoke at the fourth annual Western Cardiac Conference at Denver, Colorado, on October 11. He participated in a discussion of the value of operations on the heart for conditions such as that of President Eisenhower.

Doctor Peterman Presents Two Lectures

Dr. M. G. Peterman, Milwaukee, presented two lectures to the Chicago Medical Society annual graduate meeting on October 19. He spoke on "Neurologic Examination of the Infant" and "Convulsions in Childhood."

U. of W. Preceptors Meet

Thirty-seven state physicians attended a meeting of preceptors of the University of Wisconsin Medical School, held in Madison September 30 and October 1. Dr. John Z. Bowers, dean of the medical school, spoke on "Recent Advances in Arthritis Therapy"; and cardiovascular and tumor clinics were also held.

Dr. John Beyer Attends Course

Dr. John A. Beyer of Madison recently attended a special postgraduate course in internal medicine. The course was held at Duke University School of Medicine.

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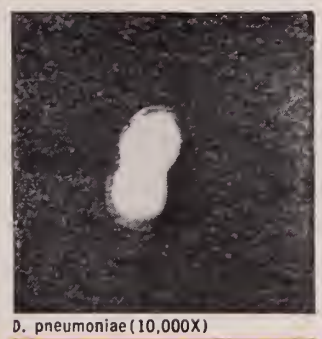
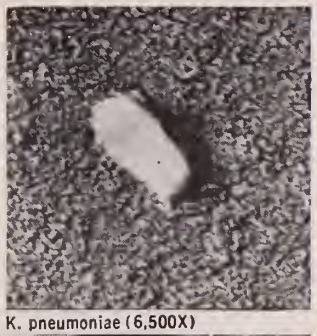
The organisms commonly involved in

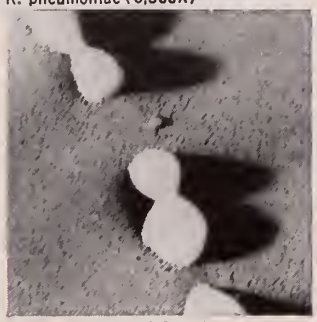
Pneumonia



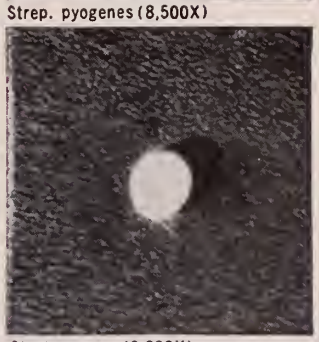
D. pneumoniae (10,000X)



K. pneumoniae (6,500X)



Strep. pyogenes (8,500X)



Staph. aureus (9,000X)

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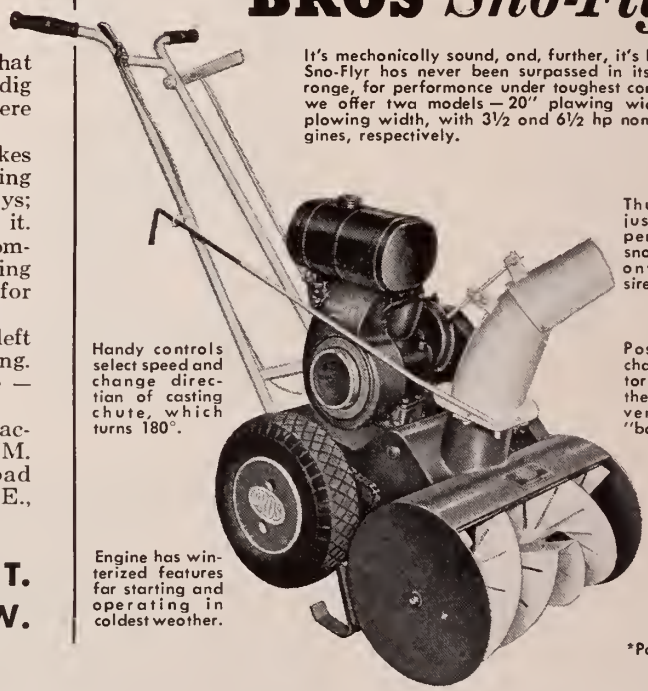

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Dr. Meyer S. Fox Speaks on Industrial Noise Problem

At a joint meeting of the Chicago Society of Industrial Medicine and Surgery and the Casualty Adjusters Association of Chicago, held at the Walnut Room of the Bismarck Hotel, Chicago, on October 19, *Dr. Meyer S. Fox* of Milwaukee was the guest speaker. Doctor Fox is chief of the ear, nose, and throat division of Mt. Sinai Hospital in Milwaukee and is a member of the Department of Otolaryngology of Marquette University School of Medicine. His subject was "The Wisconsin Story of the Industrial Noise Problem."

Dr. George Hellmuth Addresses Four Groups

Dr. George A. Hellmuth, associate professor of medicine and director of the cardiovascular section at the Marquette University School of Medicine, and chief of cardiology at Milwaukee County General Hospital, gave talks before four medical groups this fall.

He conducted a "Fireside Conference on Arrhythmias" at the national interim meeting of the American College of Cardiology at Memphis, Tennessee, on November 12.

Earlier in the season he discussed "What Does Surgery Offer in the Treatment of Coronary Disease?" and "Electrolyte Changes in Congestive Heart Failure" at the tenth annual postgraduate course of the American College of Chest Physicians in Chicago. He also addressed the Mississippi Valley Medical Society's twentieth annual meeting at St. Louis, Missouri, speaking on "The Treatment of Serious Cardiac Arrhythmias." At a meeting in Hibbing, Minnesota, sponsored by the Minnesota Heart Association in cooperation with the St. Louis County and the Mesabi Range medical societies, Doctor Hellmuth spoke on "The Diagnosis and Treatment of Cardiac Irregularities."

Doctors Speak to Natural Childbirth Association

Dr. Gerald Kring, Madison obstetrician, spoke at the first monthly lecture series of the Natural Childbirth Association in Madison on September 29. His subject was "Modern Ideas on Pregnancy."

At the second meeting on October 20, *Dr. Dorothy W. Oakley*, Madison pediatrician, spoke on "Problems Arising in Infancy."

The meetings were held in the Madison Vocational School.

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The Natural Childbirth Association was organized four years ago by a group of Madison women and the University Dames Club members and now functions as a service group to the natural childbirth classes held at the Madison Vocational School.

Dr. Bernhard Kaufman Addresses P.T.A. Meet

When the Parent–Teacher Association of the Racine–Kenosha County Teachers College held its first meeting of the school year on September 27, *Dr. Bernhard Kaufman* of Milwaukee was its guest speaker. He spoke on "The Emotional Development of the Child."

Dr. Helen Dickie Speaks at T.B. Institute

Dr. Helen A. Dickie, associate professor of medicine at the University of Wisconsin Medical School, Madison, was the guest speaker at a meeting sponsored by the Wausau Anti-Tuberculosis Association on September 20. The meeting was held at the Elks Club in Wausau.

Doctor Dickie emphasized that many tubercular patients can be cured by isolation and rest without resort to drugs.

Neurological Aspects of Internal Medicine Discussed

Thirty-one physicians from the United States and Canada attended a postgraduate course in the "Neurological Aspects of Internal Medicine" at the University of Wisconsin Medical School during the week of October 10. The course, held at the medical school this year at the invitation of the American College of Physicians, was under the supervision of *Dr. Hans H. Reese,* chairman of the Department of Neuropsychiatry at the medical school.

The annual midwest regional meeting of the American College of Physicians concluded the course on Saturday, October 15. *Dr. Karver L. Puestow,* professor of medicine at the University of Wisconsin Medical School and a regent of the American College, was in charge of the program for the meeting.

Doctor Cooney Returns from Service

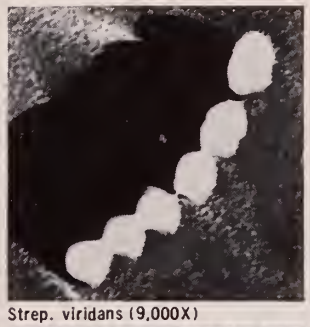
Dr. Robert T. Cooney, who practiced at De Forest prior to entry into military service in 1953, has received his discharge and has associated with the Portage Clinic at Portage. He is a graduate of the Boston University School of Medicine.

The organisms commonly involved in

Bronchiectasis

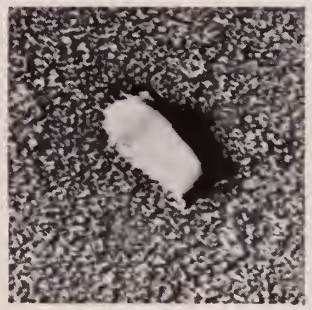
Staph. aureus (9,000X)

Strep. pyogenes (8,500X)

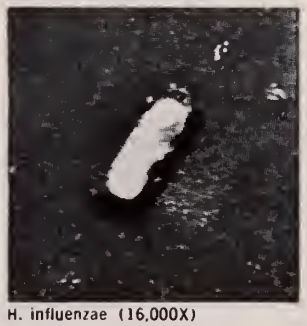

Strep. viridans (9,000X)

Strep. faecalis (10,000X)

E. coli (8,000X)


K. pneumoniae (6,500X)

D. pneumoniae (10,000X)


H. influenzae (16,000X)

Aerobacter aerogenes (12,500X)

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T. D. Foster, 8002 Barron Street, Takoma Park, Maryland.

R. E. Whitsitt, 1300 University Avenue, Madison.

J. J. Nora, Cambridge.

W. H. Pinkus, 610 Sixth Street, Racine.

Changes of Address

G. D. Reay, La Crosse, to Douglas Hospital, Douglas, Arizona.

D. W. Maas, Wood, to V. A. Hospital, Dallas, Texas.

Freddie N. Peterson, Kingston, Jamaica, B. W. I., to Lac LaBelle, Route 2, Box 17, Oconomowoc.

R. A. Turcott,** Lake Mills, to 5012th S. U. Infirmary, Fort Sheridan, Illinois.

P. E. Sadler, Madison, to 1313 North Second, Phoenix, Arizona.

T. E. Kilkenny, Elizabethtown, Pennsylvania, to 550 Lowerline Street, New Orleans, Louisiana.

J. J. Frederick, Waco, Texas, to 4449 South Packard Avenue, Cudahy.

D. F. Hammond, Chetek, to P. O. Box 0, Barron.

R. P. Reik, % Postmaster, New York, to 2920 North 56th Street, Milwaukee.

R. W. Way,** Beaver Dam, to U. S. Army Hospital, Heidelberg, Germany, A.P.O. 403, New York, New York.

H. E. Martin, Fond du Lac, to V. A. Hospital, Fayetteville, Arkansas.

** Military Service.

DEATHS

Dr. Dean Henry Jeffers, Sr., 69-year-old Lake Geneva physician, died on September 23 at a Minnesota hospital, where he had recently undergone surgery. He had practiced at Lake Geneva since 1931.

He was born on January 30, 1886, at Darien and received his medical education at the University of Michigan Medical College, graduating in 1916. He practiced at Janesville until 1918, when he moved to West Salem. In 1926 he moved from West Salem to Sparta, and in 1931 established his practice at Lake Geneva. His son, Dean Henry, Jr., had been in practice with him since 1952.

Doctor Jeffers was a member of the Walworth County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

His first wife, Lucretia, died in 1930, leaving two sons, Dr. Dean Henry, Jr., and John W. Jeffers, D.D.S., both of Lake Geneva. Doctor Jeffers' second wife, Genevieve, survives as do three step-daughters, Mrs. J. C. Moe, Lake Geneva; Mrs. Eloise Woodliff, Delray Beach, Florida; and Mrs. L. H. Donath, Wauwatosa, and a stepson, Charles Masters, Greeley, Colorado.

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Dr. Eldo T. Ridgway, 74 years of age, died October 12 at a nursing home in Lebanon, Illinois, following a long illness. He had practiced medicine at Elkhorn for many years prior to his retirement in 1947.

Doctor Ridgway was born on December 19, 1880, in Amboy, Indiana, and received his medical degree from Hahnemann Medical College and Hospital, Chicago, in 1906. He established his practice at Elkhorn in 1912 and was active until 1946, when he moved to California. He later returned to reopen his practice, and retired completely in 1947. He had been associated with Dr. E. D. Sorenson at Elkhorn during the last years of his practice.

Doctor Ridgway was a former member and president of the Walworth County Medical Society, and a former member of the State Medical Society of Wisconsin and the American Medical Association.

His wife, Leona, preceded him in death in 1946. Surviving are his son, John, of Elkhorn and three daughters, Mrs. Arnold Schendel, Runge, Texas; Mrs. P. M. Schmidt, Santa Rosa, California; and Mrs. Paul Potter, Lebanon, Illinois.

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The Journal Bookshelf

Arthritis Exposed. By Millard Tufts, M. D., Milwaukee, The Olsen Publishing Company, 1955. Price $1.50.

Doctor Tufts has rendered a great service to the many persons who have arthritis with the publication of this short, easy-to-read volume. It is astonishing that so much factual material concerning this disease can be packed into 60 pages. Cartoon-type illustrations are extremely helpful and make an excellent addition to the text. The wise use of footnotes helps to explain the definition of medical terms in those few places where it is absolutely necessary that such terms be used.

One can be critical of *Arthritis Exposed* only in a minor fashion. For instance, there are several places in which a new idea is introduced without adequately preparing the reader for it. In most cases the idea is later explained; but when one first reads it, it comes as a slight shock. Also, there are several places in which ideas are not consolidated, but rather spread throughout the book. An example is the brief mention of anemia in connection with arthritis toward the beginning of the book, the more complete explanation of it in a later chapter, and the return to it in the final pages. It is possible that a subject such as this could be dealt with more completely when it is first introduced into the reader's thinking.

Much can be said for the way in which the author explains in simple language the different types of arthritis and for his method of handling the subject of emotional tension in connection with this disease. The examples used to illustrate points regarding cause and prevention of arthritis are well selected. Best instances are the golfer who is late for his game and the automobile driver who drives for hours without taking a break and then proceeds to handle heavy luggage.

One of the high points of the book is the final chapter on encouragement for arthritic individuals. *Arthritis Exposed* is certainly not a depressing volume; but even if it were, this particular chapter would certainly tend to relieve any depression.

Members of the medical profession and laymen alike, regardless of whether or not they have arthritis, can well spend an hour reading this excellent book.—R.C.P.

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THE WISCONSIN MEDICAL JOURNAL

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Volume 54 DECEMBER 1955 Number 12

The Appendix in the Left Lower Quadrant

By J. W. McROBERTS, M. D.
Sheboygan

CONGENITAL anomalies of the gastrointestinal tract are in themselves difficult to diagnose; and when they become involved in acute pathologic processes, the problem can be most baffling. Such was our experience with 5 patients who had developmental defects that placed their appendices in the left lower quadrant.

Anomalous Rotation and Fixation

Case 1—A man, 18 years of age, developed dull, generalized abdominal pain in the afternoon. In the evening and during the night, the pain became more severe and shifted to the lower abdomen. In the morning he vomited several times, and the pain localized in the left lower quadrant. At this time the abdomen was tense, and tender throughout. However, the most painful area was in the left lower quadrant, where there was marked muscle spasm. No mass was felt. The white blood cell count was 21,000. The urine contained a small amount of albumin and a few hyalin casts. The patient's temperature was 100.8 F., the pulse 96, and respirations 20 per minute.

Since the most probable diagnosis was acute appendicitis, an operation was performed at once. A right pararectus incision was made. The small intestines lay entirely on the right side of the abdomen. The cecum and colon had a complete and lax dorsal mesentery and were located entirely on the left side. The appendix was found in the left pelvis, attached to the right side of the cecum. It was swollen, inflamed, and covered with a thick grayish exudate. After the appendectomy was performed, the patient made an uneventful recovery.

Case 2—A woman, 52 years of age, retired before midnight, feeling well. About 2 a.m. she awoke because of an acute pain in the epigastrium. Nausea and vomiting followed quickly. By the time she was seen at 4 a.m., she had passed four loose stools. She had not had similar trouble before nor any other gastrointestinal complaints. The temperature was 99 F., the pulse 84 per minute, and respirations 22 per minute. The chest was normal. The abdomen was flat. The site of pain and tenderness was the mid-epigastrium, where there was muscle spasm but no rigidity. No mass was felt. The rectal examination was negative.

My impression was that this was the onset of gastroenteritis or possibly cholecystitis.

When the patient was admitted to the hospital, her temperature was 98.8 F., her pulse 90, and respirations 20 per minute. The physical findings were the same as previously described. A scout film of the abdomen revealed nothing abnormal. The urine was normal. The white blood cell count was 19,600. The differential was as follows: polymorphonuclear leukocytes, 88%; small lymphocytes, 11%; and monocytes, 1%. The patient's condition remained the same all that day.

The following morning the pain had shifted to the left lower quadrant. There was a moderate degree of muscle spasm and some rigidity in this area. No mass was felt. Though perplexed, we thought the most likely diagnosis was acute diverticulitis of the colon.

Late that afternoon the pain was located more to the right, and there was tenderness in the suprapubic area. We decided to operate because of the likelihood of acute appendicitis. The white blood cell count now was 16,200.

The abdomen was opened through a median suprapubic incision. Turbid fluid was found in the peritoneal cavity. The cecum was found on the left side of the abdomen. It and the ascending colon had a loose, mobile posterior mesentery. The appendix, located on the

left side of the cecum, was swollen and acutely inflamed, and had dark gangrenous areas. The surrounding bowels and mesentery showed the typical picture of localized peritonitis. Except for the cecum and ascending colon, the large and small intestines were in their normal positions. The appendix was removed and a rubber tissue drain left in place.

The patient made a good recovery with the help of gastric suction, penicillin, streptomycin, and intravenous fluids.

Case 3 was a nurse, 21 years of age; and **Case 4** was a child, 12 years of age. The clinical course and pathology in these 2 patients was closely similar to that in the second case.

COMMENT

Four examples of anomalous bowel fixation or rotation in early fetal life have been given.

The first case probably illustrates a complete failure of rotation. The cecum was in the left side of the pelvis, and the colon had a complete dorsal mesentery and was to the left of the midline. The small intestines were all on the right. It was not determined at operation whether the jejunum passed in front of or behind the superior mesenteric artery.

The three other cases represent a failure of fixation and retention of the dorsal mesentery of the cecum and ascending colon.

The most common abnormality of rotation is the cecum remaining fixed in the region of the gallbladder or right kidney after rotation has been completed. Most general surgeons, I am sure, have been disturbed when the cecum cannot be found through the customary McBurney incision. Often the cecum is located high in the right upper quadrant, due to abnormal fixation. The surgeon must not hesitate to enlarge the incision upward in such cases.

Let us consider the normal development and excursions of the intestinal tract and, more particularly, of the midgut. Due to the rapid increase in size of the liver and other abdominal organs in the fourth week of intrauterine life, there occurs a physiological hernia of this part of the gut into the umbilical cord.

When the gut starts to re-enter the peritoneal cavity between the fifth and tenth weeks, it is subject to various stages of rotation. The first stage is a simple anticlockwise rotation of 90 degrees. By this twist, the duodenum and left colic flexure are brought into close approximation.

The second stage consists of a further rotation of 180 degrees in the same anticlockwise direction. At this time the midgut returns to the abdominal cavity, duodenum and jejunum in the lead. The proximal loop of bowel is deflected by the liver to the right side of the abdomen, and by further rotation comes to lie under the taut axis of the superior mesenteric vessels.

The jejunum and ileum follow the same pattern and come to be entirely on the left side of the abdomen. The cecum and right colon re-enter in due course and come to lie on the right.

The third stage is a comparatively simple one, involving the descent of the cecum and proximal colon to their normal adult positions and the fixation of the mesentery to the posterior parietes. In addition, the whole midgut becomes fixed in an oblique line to the posterior abdominal wall from the duodenum, lying behind the superior mesenteric vessels towards the right iliac fossa.

The mobility of the mid and hind guts depends on the extent of peritoneal fusion and fixation; when fixation occurs early, the

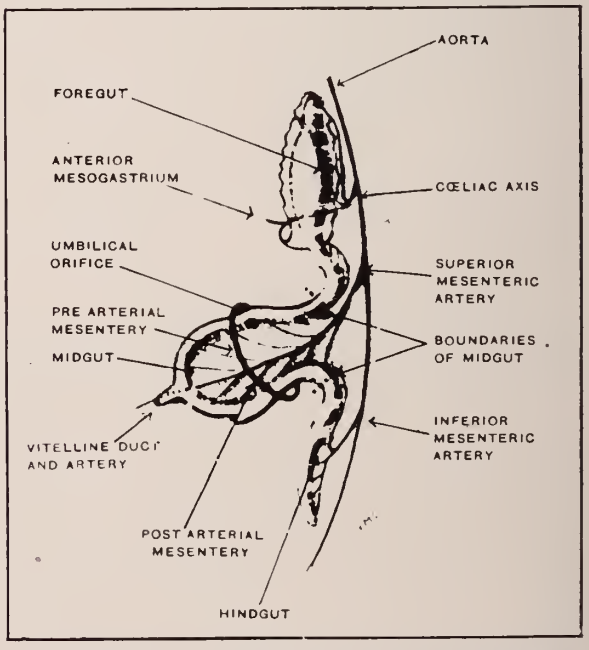

Fig. 1—Primitive alimentary tract, fifth week. Three main subdivisions constitute three loops: foregut, midgut, hindgut. Aorta representative of axis of body. From it three loops suspend by common mesentery in sagittal plane. Special arterial supply for each loop in mesentery. Midgut loop already large, extrudes into umbilical cord. Cecal bud appearing.

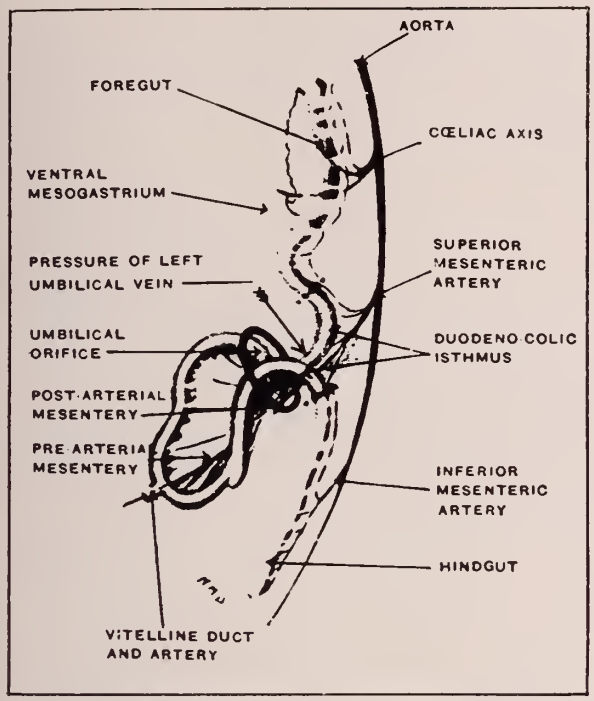

Fig. 2—Eighth week. First stage of rotation. Arrow indicates pressure exerted by left umbilical vein upon pre-arterial segment of loop, forcing it downward and to right. Note narrow duodenocolic isthmus at base of loop. Superior mesenteric artery runs through it.

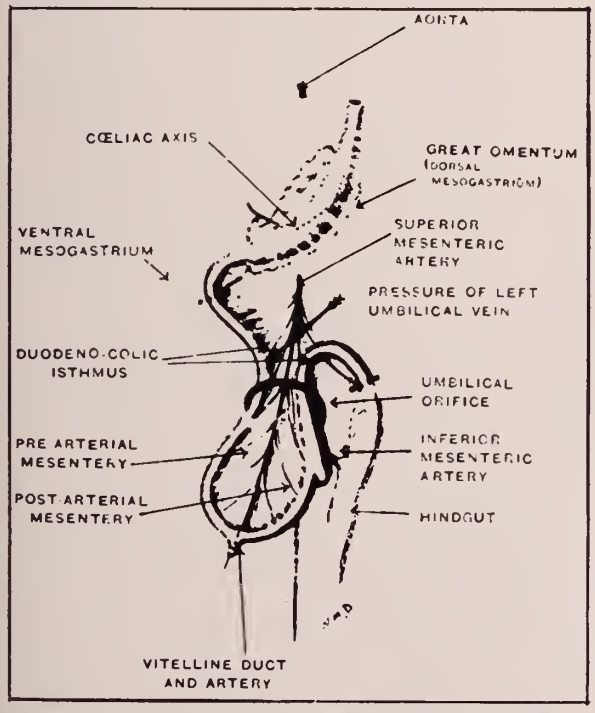

Fig. 3—Eighth week, ventral aspect. Note right-sided position of small intestine and left-sided disposition of large intestine at this early stage of rotation. In "non-rotation" these relations are maintained.

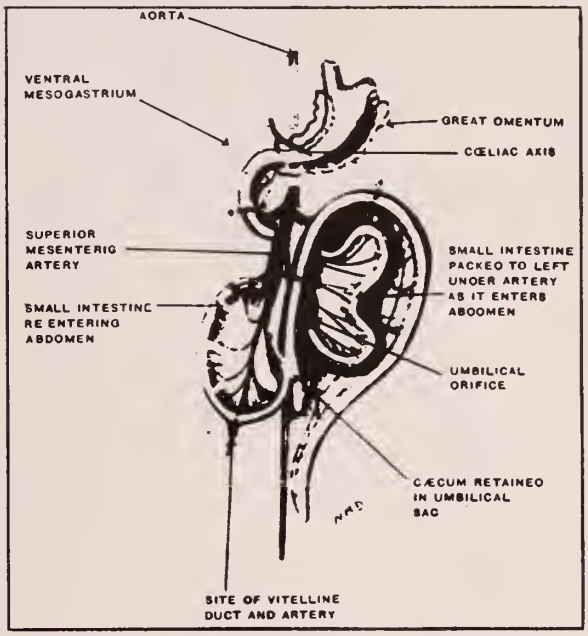

Fig. 4—Tenth week. Pre-arterial segment of loop, the small intestine, has increased in length disproportionately to post-arterial segment; its mesentery has shared its rapid growth. Cecum and adjacent colon have grown relatively thick. Temporary umbilical hernia is in process of reduction. Small intestine enters abdomen on right side of superior mesenteric vessels and passes to left side of abdomen behind mesenteric vessels to fill available space. Vessels are held forward to umbilicus by cecum, which still lies in sac. Second stage of rotation is in progress.

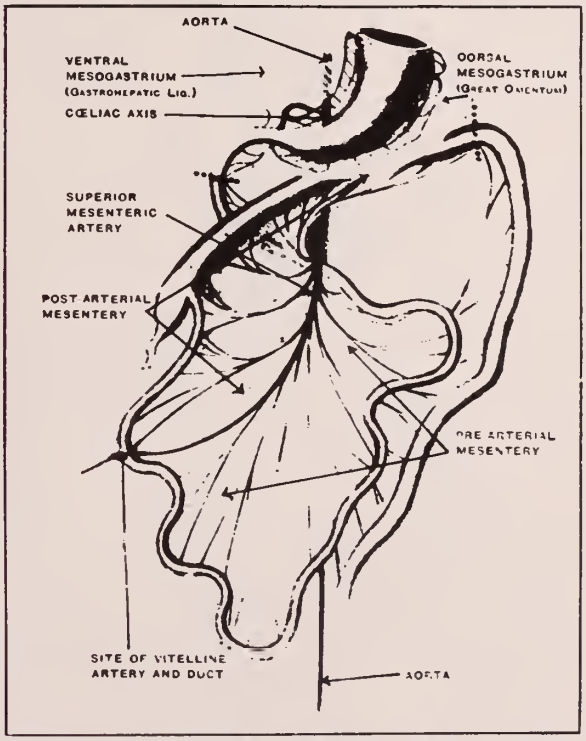

Fig. 5—Eleventh week. Second stage of rotation complete. Cecum now in contact with posterior abdominal wall at right loin. Midgut loop has rotated on axis of superior mesenteric vessels through 270° from original sagittal plane. Essentials of permanent disposition of viscera have been attained.

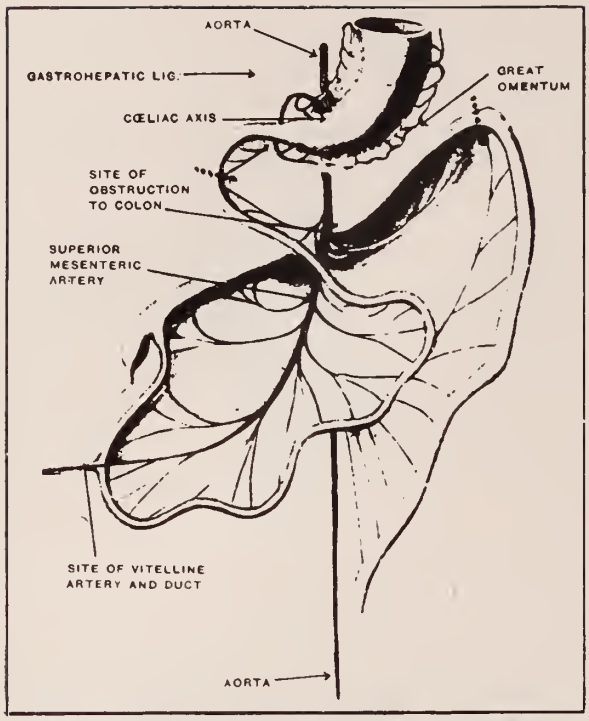

Fig. 6—Reversed rotation of midgut loop. Midgut loop has rotated in a clockwise direction through 90° from original sagittal plane. Colon lies behind mesenteric vessels and duodenum in front. Viscera otherwise in normal position, but anterior and posterior surfaces reversed.

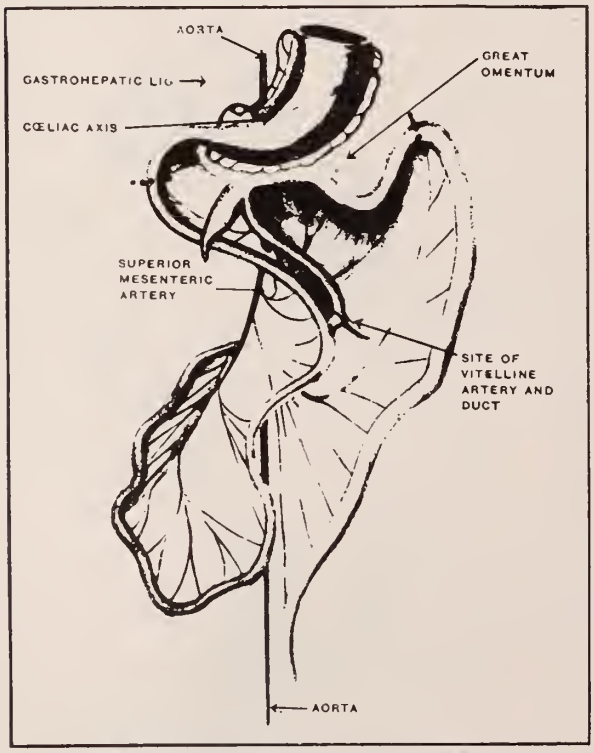

Fig. 7—Malrotation of midgut loop. Reversed rotation of pre-arterial segment through 90° in clockwise direction. Arrested rotation of post-arterial segment. Mesentery folded, as on a hinge, at line of superior mesenteric artery.

cecum remains high in the subhepatic region. Deficient fixation results in a mobile cecum which tends to prolapse into the pelvis and may lie to the left of the midline. This illustrates the situation found in our patients.

Transverse Position of Viscera

Case 5, 24 years old, was known to have dextrocardia, previously discovered by a routine chest film. Her complaints were recurrent, dull, nagging pains in the left lower quadrant of the abdomen over a period of several years. There was no history of nausea or vomiting associated with these attacks. Bowel movements were always normal. Menstruation was regular and normal and not related to the symptoms.

An anteroposterior film of the abdomen and pelvis revealed a transposition of the abdominal viscera, with the liver on the left side, the stomach on the right side, the cecum on the left, and the descending colon on the right.

At operation a left McBurney incision was made. The cecum was directly under the wound and was delivered easily. The appendix was long and thin and contained several fecal concretions. It was removed in the usual manner, and the stump was inverted.

The patient was also found to have a well-formed Meckel's diverticulum, about 18 inches from the ileocecal valve. It was about 10 cm. in length and 2 cm. in diameter at its base. The diverticulum was completely removed and the stump inverted.

The lumen of the appendix was filled with fecaliths and the mucosa was mildly eroded. No inflammation or abnormal secretory glands were seen in sections made from the Meckel's diverticulum.

The patient made a good recovery from the operation and did not thereafter complain of pain in the left lower quadrant of the abdomen.

COMMENT

The cause of transposition of the viscera can be stated as follows: In the first stage of embryonic life, the thoracic and abdominal viscera are aligned at about medium plane. Normally, a rotation of the viscera to the right side occurs. When rotation takes place to the left, with a sinistral instead of dextral spiral, transposition of the viscera occurs.

Cockayne[1] states, "Complete transposition of the viscera is inherited as a recessive and is determined by a single autosomal gene."

Summary

Four cases of acute suppurative appendicitis in which the appendix was situated in the left lower quadrant of the abdomen have been presented. The abnormal location of the appendix was due to a failure of fixation of the large bowel and to abnormal rotation of the bowel during early fetal life.

A fifth case presented was one of situs viscerum inversus. The appendix and a Meckel's diverticulum were removed through a left McBurney incision.

1011 North Eighth Street.

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2. Dott, N. M.: Anomalies of intestinal rotation; their embryology and surgical aspects, Brit. J. Surg. 11:251–286 (Oct.) 1923.

(Illustrations are reproduced from Dott's original article.)

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1955, the March of Medicine began its tenth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 40 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WATK	Antigo	Saturday	8:45 a.m.
WHBY	Appleton	Saturday	8:30 a.m.
WATW	Ashland	Saturday	8:15 a.m.
WHSA	Brule	Saturday	1:15 p.m.
WHKW	Chilton	Saturday	1:15 p.m.
WCHF	Chippewa Falls	Saturday	9:00 a.m.
WHWC	Colfax	Saturday	1:15 p.m.
WHAD	Delafield	Saturday	1:15 p.m.
WEAU	Eau Claire	Saturday	11:45 a.m.
KFIZ	Fond du Lac	Saturday	4:00 p.m.
WBAY	Green Bay	Saturday	2:45 p.m.
WHHI	Highland	Saturday	1:15 p.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	10:45 a.m.
WLDY	Ladysmith	Saturday	9:30 a.m.
WHA	Madison	Saturday	1:15 p.m.
WIBA	Madison	Saturday	11:00 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Saturday	11:45 a.m.
WDLB	Marshfield	Saturday	9:45 a.m.
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WEKZ	Monroe	Friday	2:00 p.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WSWW	Platteville	Friday	1:45 p.m.
WPLY	Plymouth	Saturday	8:30 a.m.
WIBU	Poynette	Thursday	2:45 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:15 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WRDB	Reedsburg	Tuesday	9:30 a.m.
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WRCO	Richland Center	Wednesday	1:30 p.m.
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WLBL	Stevens Point	Saturday	1:15 p.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m
WTTN	Watertown	Tuesday	11:30 a.m.
WSAU	Wausau	Saturday	9:15 a.m.
WBKV	West Bend	Saturday	11:30 a.m.
WHLA	West Salem	Saturday	1:15 p.m.

Present Concepts of Benign and Malignant Breast Conditions*

By HERBERT C. LEE, M. D.
Richmond, Va.

IN 1940 a middle-aged Italian lady came to us with an obvious carcinoma of the breast. She had large axillary masses and palpable supraclavicular nodes. By all standards she was inoperable as well as incurable. To prevent ulceration and to remove the uncomfortable axillary nodes, a radical mastectomy, including a supraclavicular dissection, was carried out. The family was told how useless the procedure was and that the patient's survival beyond six months was unlikely. This lady recently came back to see me because of palpable cervical nodes. We were, of course, delighted, but amazed to see her, and were further surprised when these nodes proved to be inflammatory. Here was a 15-year survival in a patient who today would have probably been refused surgery.

A short time ago another lady, in her late thirties, was seen because of a small lump in her breast. A biopsy proved the nodule to be malignant, and a radical mastectomy was done. No further tumor was found in the breast after the excision of the nodule, and no tumor was found in the axillary nodes. A reasonable chance for complete cure was expected, yet this woman was dead within eight months with generalized metastases from carcinoma of the breast.

These two cases should be kept in mind as we proceed because they typify the main problem in breast pathology as we see it today.

The title of my paper is a misnomer. The modern treatment of diseases of the breast is so varied in its application that there is little uniformity of opinion as to what form is proper. In many respects it is not even modern, as some forms of treatment are no different than they were 50 years ago. The treatment of breast lesions is both standardized and variable, static and changing; and for all practical purposes we are no further along in saving lives from lesions of the breast than we have ever been.

The basis for all treatment in breast conditions is proper treatment of benign lesions so as to rule out malignancy and control the symptoms, and proper treatment of malignant lesions so that the disease may be eradicated. Let us proceed to examine these conditions and see how well we are doing in this so-called miracle age of medicine.

Benign Breast Lesions

Benign lesions of the breast are completely benign, have a malignant potential, or are precancerous. It behooves us to know the symptoms and characteristics of each condition so that we will give proper treatment, will biopsy all suspicious lesions, and will be prepared to reassure the patient that the condition is truly benign.

It seems unnecessary to repeat the old adage, "When in doubt, biopsy." Haagensen found that 27% of his referred patients who had cancer of the breast had had insufficient advice and treatment by their referring physicians. It is our divine duty as physicians to properly diagnose and treat our patients' diseases or to refer the patients to someone else when there is the slightest doubt as to the proper course to follow. A well-trained and experienced physician, particularly a surgeon, should be able to correctly diagnose 90% of all breast lesions grossly. The remaining 10% must be biopsied, and this should also be done in many of the original 90% to make certain that the gross diagnosis is correct. We must remember that the easiest way is to biopsy them all, yet this is not only unnecessary, but is also impractical. The first step in the treatment of any disease or lesion is the making of a proper diagnosis. The correct treatment of each benign lesion is fairly well standardized once the diagnosis has been made. Our discussion will consider both diagnosis and treatment of these lesions.

* Presented at the One Hundred and Fourteenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, May 5, 1955.

CLASSIFICATION

The common benign breast conditions are:

1. Cystic disease
   a. Mastodynia
   b. Adenosis
2. Intraductal papilloma
3. Fat necrosis
4. Granulosa cell myoblastoma
5. Comedo mastitis—duct ectasia

The latter three achieve importance because they are benign conditions which resemble malignant disease.

Chronic cystic disease or, more commonly, chronic cystic mastitis, is one of the pathologic conditions most likely to affect females; however, its true incidence has never been determined. Frantz found the condition in 53% of 225 breasts at autopsy. Other pathologists have placed the incidence higher than this, Semb finding cystic changes in 80% of breasts removed as surgical specimens. Pathologists and surgeons are often at disagreement as to what represents cystic diseases. The term is a catchall for a large group of changes ranging from cysts to fibrosis. It represents a condition in which there are clinical changes in the breast, usually in the upper outer quadrant, and usually bilateral. The disease, by its very nature pathologically, is of long duration. In the early form, or adenofibromatosis, the breast contains a flattened, granular mass, which, in the early stages, presents cystic swelling and tenderness premenstrually; the condition lessens as the period progresses. In later stages the condition is permanent. The pain and swelling are due to venous engorgement and not to epithelial proliferations.

Normal lobule formation is dependent on the proper ratio of estrogen and luteal hormones. The fibrous form of cystic disease, **mastodynia**, results from a reduced function of the corpus luteum. Cystic disease is due to an intense or unopposed estrogen stimulation. There is a variety of forms of the disease, yet the development of cysts is the common factor. They may be single or multiple. They may have lost their epithelium, may have normal epithelium, or may have hyperplastic epithelium with papillary proliferations. The common blue dome cysts have no epithelial proliferation, and they are harmless. The remainder represent a condition that is most common at or near the menopause and which is usually painless and not cyclic. The isolated nodules of this condition resemble a malignant condition, and all require a biopsy for correct diagnosis.

Adenosis represents the least common form of cystic mastitis, and it is characterized by nodules in one or both breasts. The pathology is diffuse, or limited with an increase in periductal and perilobular fibrous tissue. Small cysts, minute adenomas, papillomata, and dilated ducts are characteristic; and in advanced cases the intraductal hyperplasia and epithelial proliferation of the acini produce a picture that resembles carcinoma. These patients usually have pain and menstrual complaints and are usually underweight, nervous, and physically upset. The pathological changes of adenosis are not an essential factor in the development of cancer, but they do represent the changes of hyperestrinism, which, experimentally, leads to the production of cancer in animals.

In an attempt to classify all forms of so-called chronic cystic mastitis, Foote and Stewart have broken down the classification into eleven groups. The first five form the cystic or proliferative group; these authors have not been able to find local factors which could be interpreted as causing cancer, though. Many investigators have tried to find a relationship between chronic cystic mastitis and cancer, but we are no closer to agreement on this question than we have ever been.

Obviously, cases of mastodynia can be controlled with hormones, and no biopsy is necessary. Other forms of chronic cystic mastitis will frequently require biopsy to rule out malignancy. The treatment of the cystic form of mastitis is difficult because it is hard to tell which masses are simple cysts or nodules. There is general agreement that the larger cysts are much less likely to eventuate in carcinoma than the smaller ones. No one questions the dictum that all solid, localized masses in the breast should be removed for microscopic study. However, it has been shown that aspiration is an extremely valuable measure for both diagnosis and treatment of single or multiple cysts, provided certain precautions are taken, as suggested by Johnson:

1. All masses which do not completely disappear after aspiration, or which refill after two aspirations, should be immediately excised.

2. If grossly bloody fluid is obtained, aspiration should be abandoned and immediate biopsy carried out.

3. Smaller cysts near the areola should not be aspirated, for they may represent dilated ducts and contain papillomata.

4. The fluid aspirated should always be examined cytologically, and cysts with suspicious findings should be excised. The only exception to this is the typically bluish fluid from blue dome cysts, which is pathognomonic; these cysts will promptly disappear.

5. Aspirations should be done only by one trained in surgery of the breast and aware of its limitations.

6. All patients should be instructed in breast self-examination and followed closely by their physicians, since a malignant potential of ½% remains even when cysts are aspirated or excised.

Aspiration of breast cysts, with its obvious limitations, is a most gratifying and dramatic procedure. When patients who are convinced they have a malignancy learn that the mass has disappeared with simple aspiration, there is a psychic relief and gratitude that would be hard to exaggerate.

Intraductal papillomata occur as papillary projections in the lumina of the major ducts of the breast. They are more common in the circumareolar area but can be anywhere in the ducts. They are usually single but may be multiple and, rarely, are bilateral or simultaneous. These papillomata may be found in a normal breast or may be associated with other breast pathology. They are usually diagnosed by observing bleeding from the nipple or by actual palpation of the area. When present, the entire duct and papilloma should be excised and studied for the presence of malignant changes. These papillomata are almost invariably benign; but occasionally one will show some invasion, and such a lesion must be considered as malignant.

Much significance has been attached to the bleeding nipple—chiefly because it is occasionally an indication of the presence of cancer. Most commonly, though, the cause of the bleeding is a benign condition. However, the presence of bleeding should indicate a malignant lesion until proved otherwise. Duct papillomata, chronic cystic mastitis, and cancer are the chief causes of bleeding; but trauma, inflammatory lesions, sarcoma, hormonal dysfunctions, and Paget's disease are other causes.

Whatever the cause, the symptom demands investigation. Accurate localization of the source of the bleeding is the first problem, and it is often a difficult one requiring repeated examinations. If a palpable tumor is present, the problem is simplified; but often there is no lump. Consequently, the breast must be carefully palpated by radial digital pressure and the entire breast covered slowly until the blood is "milked" from the proper duct. After a source is found, the remainder of the breast should still be examined for other evidence of bleeding. The secretions can be studied with the Papanicolaou technique; but regardless of findings on using this smear, the offending area must be excised. Either the duct and papilloma or other pathology is excised, or a wedge resection of this area of the breast is done. This treatment, conservative as it is, is proper. However, if bleeding continues or if there were multiple lesions, more radical surgery may have to be done.

Fibroadenomas are among the most frequent tumors that occur in young women and are particularly common in the Negro. They are firm and solid and are round or lobulated. They are usually freely movable and not attached to the skin or surrounding tissue. These tumors will change in size during the various phases of the menstrual cycle and most noticeably during pregnancy. Since it is generally conceded that all solitary breast nodules should be excised, we believe fibroadenomas should be removed. They are readily diagnosed grossly, and there is no particular hurry about their removal unless the patient is pregnant or the lesion is growing. Stout has seen carcinoma in a fibroadenoma only once in thousands of cases. The reason for advising removal is to be certain.

Fat necrosis, granulosa cell myoblastoma, and **comedo mastitis** or **duct ectasia** are all benign conditions; but they resemble carcinoma grossly. All of them require biopsy for diagnosis; when the findings indicate the presence of one of these it is gratifying to both surgeon and patient, the latter having already been advised of the possibility that the breast might have to be removed.

Thus, we have briefly covered the main benign breast lesions. There is nothing new

here, but it pays occasionally to restate certain truisms so that we may remain aware of the presence of these lesions, look for them, and properly take care of them. If any of the benign lesions show evidence of carcinomatous changes, the proper treatment becomes an immediate, more radical affair.

Malignant Breast Lesions

Carcinoma of the breast is the most common type of cancer found in women, yet the mortality from this type of cancer in the general population is third in frequency, following mortality from cancer of the stomach and of the intestines. Each year in New York State one new breast cancer per each 1,666 of the population—or 60 new cases each year per 100,000 of population—develops in women. Based on these figures, Richmond, a city of roughly 200,000 people, should have approximately 120 new cases each year. When these cases are divided among the qualified surgeons, each operator has relatively few cases; and an occasional operator will have little experience in the field. In the Medical College of Virginia hospitals in 1954, over 13,000 operations were performed; and there were 229 breast specimens examined. Thirty-eight patients had radical mastectomies, and 12 had simple mastectomies. There were 165 biopsies or excisions and 11 wedge resections. All of the cases of carcinoma did not have radical treatment for one reason or the other; 38 did, and seven radical operations were the most done by any one surgeon. I mention this fact only to show that any one individual cannot collect a massive series of cases or gain proficiency in any one type of operation, and this factor alone may be a reason why the mortality of cancer of the breast is practically what it was 50 years ago, in spite of the rapidity with which medicine is changing today.

We hear much today about the necessity of early diagnosis, the avoidance of unnecessary delays, the advantages of self-examination, and the importance of biopsying all suspicious lesions. Although these are all proved factors in decreasing mortality from cancer, there are many reasons why a cancer of the breast, or the mortality therefrom, may not be affected by any of them.

There are certain factors inherent in a patient when first seen, all of which are beyond our control. These are the location of the tumor; size of the tumor; histologic grade of the tumor; extent of skin and axillary node involvement; actual duration of the disease (not of symptoms); age of the patient; and her physiologic state—whether or not she is pregnant, whether she is lactating, whether she is pre- or post-menopausal. The real cause of failure in our present treatments may lie in any one or all of these factors. It can be readily seen that the earlier the diagnosis is made, the better. It can also be seen that it is impossible to predict the prognosis in any given case. There is twice as much breast cancer as any other type of cancer affecting women, yet until recently there had been no change in the surgery of this type of cancer since radical mastectomy was introduced by Halsted and Meyer 60 years ago, and no change in roentgen therapy since high voltage therapy began 30 years ago.

Sixty per cent of the cases have axillary involvement when first seen, and this figure has remained constant through the years. We do seem to have two to three times the clinical material that we used to have, and many clinics and surgeons are trying to use this material in various fashions in an attempt to improve the discouraging results obtained in cancer of the breast.

In a radical mastectomy operation there are certain fundamentals, including adequate removal of the skin in the region of the lesion; complete dissection of the axillary lymph nodes; and the *en bloc* removal of the breast, overlying skin, pectoralis muscles, and all axillary lymph nodes and node-bearing fascia. This classical operation, with cure as the objective, has given us a five-year survival rate of about 50% if the axilla is uninvolved and about 30% if it is involved. This is obviously not enough.

As there are some factors beyond our control, there are also some, most of which deal with the technique of the operation, that are within the surgeon's control. Some of these factors are the amount of skin excised, the manner of skin flap dissection, the amount of axillary nodes removed, the avoidance of operative trauma, and the completeness of the removal of both pectoral muscles. The tragic fact, however, is that, regardless of how one feels about these factors, in actual practice the mortality remains stationary.

Realizing that radical mastectomy was

universally used and denied to no one, Haagensen and Stout felt that its use on obviously inoperable cases was not only decreasing the effectiveness of the procedure, but was also shortening the lives of many people unnecessarily. In 1946 they presented the following "criteria of operability" based on many thousands of cases; and radical surgery was denied to anyone in the inoperable category:

Criteria:

Breast carcinoma is inoperable:

1. When extensive edema of the skin over the breast (involving more than 1/3 of skin area) is present.
2. When satellite nodules are present in the skin over the breast.
3. When the carcinoma is the inflammatory type.
4. When two or more of the following signs of locally advanced carcinoma are present:
   a. Ulceration of the skin
   b. Edema of the skin of limited extent (involving less than 1/3 of skin over breast)
   c. Fixation of tumor to chest wall
   d. Axillary lymph nodes measuring 2.5 cm. or more in transverse diameter
   e. Fixation of axillary lymph nodes to the skin or the deep structures of the axilla
5. When there is edema of the arm.
6. When, in patients with clinically involved axillary lymph nodes, a supraclavicular dissection reveals metastases in the supraclavicular lymph nodes.
7. When, in patients with clinically involved axillary lymph nodes, biopsy of the internal mammary lymph nodes reveals metastases.
8. When roentgenographic study of the skeleton reveals metastases or when the patient has a history of recently developing pain in the back or pelvic region suggesting metastases.
9. When roentgenographic study of the lungs reveals metastases.
10. When palpation of the liver suggests that it contains metastases.

Most surgeons have adopted these criteria as "gospel," although there is honest disagreement with some of them. One of the original criteria, carcinoma in pregnancy, has since been discarded as many people survived five years or more with this combination. No other agent except surgery can be thought of in terms of effecting a cure, and we believe with Adair that these criteria are too strict. It seems wrong to select just the most favorable cases for surgery, leaving the rest to hormones and x-ray when we know full well that such action is palliative only. We feel that all patients should be allowed the radical operation unless the supraclavicular nodes are involved, the breast or axillary involvement is fixed, or there is evidence of distant metastases. In other words, all cases are operable if the disease is localized to the breast or the breast and axilla and if there is a chance for cure, no matter how small that chance.

In recent years the classical radical mastectomy has been under attack from several quarters. Delande followed 100 untreated cases of carcinoma of the breast and found that 22% survived five years after the origin of the disease without any treatment whatsoever. In Scotland, McWhirter advocated simple mastectomy and thorough irradiation; and his five-year survival rates were higher than any reported series using the accepted radical operation, regardless of how strict an application of criteria for operability was imposed. Certain authors felt that radical mastectomy was obsolete and that the operation should include the supraclavicular nodes and the internal mammary groups of nodes if the axillary nodes were positive for metastases. In 1949, Dahl-Iversen did routine supraclavicular dissections along with radical mastectomy and found that 17% of the glands in this area were involved with tumor. If the axilla had already been invaded, 33% of the supraclavicular nodes had been invaded; if the axilla had not been invaded, none of the supraclavicular nodes were involved. The question of supraclavicular dissection, which had been previously tried and abandoned by Halsted, was thus reopened.

In the early 1920's, W. S. Handley excised the internal mammary nodes in 5 patients; he did not continue to use this procedure, however, because it made the operation too prolonged and too severe, and he advised the parasternal insertion of radium tubes instead. In 1947 his son, R. S. Handley, began to biopsy the second intercostal space for

lymph nodes after a radical mastectomy. By July, 1952, he had found these nodes positive for tumor in 34% of 117 patients. In other words, in a third of the operable cases a chance for cure was gone before treatment was started. In 1951 Dahl-Iversen did the same thing. After a radical operation in 53 operable cases, he biopsied the second, third, and fourth intercostal nodes and found tumor in 19% of the cases; yet only 47% had positive axillary nodes.

In 1951 Urban began a block dissection of the internal mammary nodes along with radical mastectomy. Of his first 57 cases, with the tumor in the inner half of the breast, 20 were free of metastases. Of 33 patients with positive axillary nodes, 73% had positive internal mammary nodes; and 4 patients with negative axillary nodes had positive internal mammary nodes. The Urban operation entails an *en bloc* removal of the chest wall, including the ribs and edge of the sternum, in an area extending from the first to the fifth rib and including the internal mammary artery, vein, and chain of lymph nodes. This "trap door" is then removed with the breast and axillary contents. The defect in the chest wall is replaced by a fascial graft. Urban had only one death in his first 80 cases, and the patients averaged only eight days in the hospital after operation.

After Handley showed how many patients have involvement of the internal mammary nodes, the logical conclusion was to biopsy the internal mammary chain in every operable case before proceeding with the radical mastectomy. If the internal mammary nodes were positive, no radical operation was done.

Wangensteen, as you know, was not satisfied with this conclusion, and several years ago began doing a "super radical" mastectomy. He does the classical Halsted operation plus: (1) a supraclavicular dissection with the clavicle retracted laterally; (2) an excision of the internal mammary chain of vessels and nodes; (3) excision of the contralateral chain of internal mammary vessels; and (4) a mediastinal dissection. In his first group of patients so treated, he found tumor beyond the scope of the usual operation in 60%. As yet, Wangensteen has made no formal report of his operations or of the mortality or morbidity connected with such an extensive procedure. It is too early to assess any such operation. At present, suffice it to say that the procedure is technically feasible.

Andreassen and Dahl–Iversen removed the supraclavicular nodes along with a radical mastectomy in 98 patients in one year. Of those with positive axillary nodes, 33% were also found to have occult supraclavicular node metastases, none of which were palpable preoperatively.

In order that we may properly evaluate these operations and also these remarks, we should review the essentials of the lymphatic drainage of the breast (as described by Haagensen).

There are two main routes for metastasis from a primary focus of breast carcinoma to the supraclavicular nodes; one is from the axillary nodes, the other is from the internal mammary nodes. The main route is via the axilla, where there are five main groups of nodes. The main collecting trunk lymphatics run upward along the lateral aspect of the breast to reach the scapular and central groups of axillary lymph nodes. From these groups of nodes, trunk lymphatics run medially to the highest group of axillary nodes, the *subclavicular* group. This important group of nodes is situated upon and caudad to the axillary vein just before the point where it passes medially beneath the clavicle.

Two other groups of collecting trunk lymphatics from the upper part of the breast go directly to the subclavicular nodes. The *interpectoral* collecting lymphatics, after rounding the free edge of the pectoralis major muscle, run upward and medially to an inconstant interpectoral (Rotter's) node or nodes lying between the pectoralis major and minor muscles, and thence directly to the subclavian group of nodes. The *transpectoral* collecting lymphatics follow the pectoral branches of the thoracoacromial vessels through the pectoralis major muscle and go directly to the subclavian group of nodes. We have never seen a five-year survival if Rotter's nodes were positive for tumor.

When metastases reach the subclavicular group of nodes, operation does not cure. From these nodes one or two trunks pass up beneath the clavicle parallel to the subclavian vein to reach the grand central lymphatic terminus at the confluence of the internal jugular and subclavian veins. These trunks empty into the venous stream; but just before they do so, they often pass through an inferior, deep, final sentinel cervical lymph node lying upon the confluence of the internal jugular and subclavian

veins. When this node is enlarged, it can be palpated behind the lateral edge of the sternocleidomastoid muscle. It is 2 or 3 cm. from the subclavicular nodes.

There is no direct pathway from the axillary to the supraclavicular nodes. When the supraclavicular nodes are positive, the invasion is retrograde from the sentinel node.

Metastases can also reach the supraclavicular nodes from the internal mammary route. On each side of the base of the neck the internal mammary lymphatic trunk empties into the grand central lymphatic terminus and goes either to the blood stream or to the sentinel node. It is thus possible to have positive supraclavicular nodes without positive axillary nodes, although the internal mammary nodes usually do not become positive until after the axillary nodes are involved.

The internal mammary nodes lie in fatty areolar tissue on the endothoracic fascia and in the plane of, or superficial to, the internal mammary artery and vein. They are between the costal cartilages within 3 cm. of the sternum. They are not easy to find.

The axillary route is the main route of lymphatic drainage from the entire breast. Emboli go there first even if the cancer is in the inner half of the breast. As the axillary nodes get involved they plug off further flow and then some emboli go to the secondary routes. From the central and inner half of the breast, they go to the internal mammary nodes.

Haagensen found that the second intercostal node is most often positive. This node is a poor filter; when it is filled, the spread is up or down the chain either to the terminus or to the liver. In 1951, Haagensen began to biopsy the internal mammary node prior to doing a radical operation if the axillary nodes were palpable and positive; if there was a large tumor in the center of the breast—also if the tumor was lying in the inner half of the breast; or if the extent of the local disease made operability questionable. He feels that a positive internal mammary node leaves a patient incurable and hence inoperable. For several years he has done a triple biopsy: (1) The tumor; (2) The second, third, and fourth intercostal spaces and nodes; and (3) A supraclavicular dissection. This procedure takes two to three hours to complete. If all the nodes are negative, he does a radical mastectomy a week later. He recently made this a quadruple biopsy by also sampling the body of the second lumbar vertebra. Thus, he has further delineated his criteria of operability and reduced to the least common denominator the number of cases amenable to cure. More recently still, he abandoned the supraclavicular biopsy as not critical enough, and substituted a high axillary node biopsy.

Haagensen has little patience with Wangensteen's operation. He feels that if the disease has not reached the terminus, the super radical operation is too radical, and if it has reached the terminus, the disease is too far advanced and operation is futile. He feels that the Wangensteen operation increases morbidity without increasing the cure rate. Haagensen feels that removal of the internal mammary chain is not justified unless a preliminary biopsy has shown the highest axillary nodes to be free of tumor, or unless a preliminary biopsy of the first intercostal space has shown that the tumor has not reached that level.

A meticulous surgeon, Haagensen limits his surgery to cancer of the breast. He removes wide margins of skin, dissects thin skin flaps, and grafts all of his patients. He has shown that the more axillary nodes the surgeon removes, the higher the percentage of cures, and that the careful, deliberate operator has a lower mortality rate and lower recurrence rate, with twice as many five-year survivals as other operators. Haagensen thus feels that the three to four hours needed for the biopsies and the five to seven hours required for the radical mastectomy are warranted.

My students often ask me about surgeons they have complete confidence in who spend 1½ hours on a radical mastectomy and feel they are doing as good a job as anyone. They want to know who is right. We all operate according to the dictates of our own consciences. Qualified surgeons of course know *what* should be done in a radical operation. Hence, the only difference between a two-hour and a seven-hour operation is in the technique. The thinness of the skin flaps and the ease with which they are dissected; whether the knife or cautery is used; the extent of development of the skin flaps; the manner of controlling bleeding; the completeness of the axillary dissection; the necessity for a graft as against primary clo-

sure—all of these are factors. My late chief taught that a so-called radical mastectomy completed in less than 2½ hours is actually not a radical mastectomy. The average length of time most of us take in doing the operation is probably 2½ hours; it is seldom less than that. One of America's most respected surgeons never took more than 40 minutes to do a radical. He did what he felt was necessary. He also did his own pathology so a check on his survival rate might be fraught with errors.

We are now reduced to a bare minimum of cases in which to do a radical operation. The remainder are considered inoperable and are turned over to the roentgenologist or are treated with hormones.

Palliative treatment consists of one or all of the following:

1. Surgical castration
2. Adrenalectomy
3. Hypophysectomy
4. Use of estrogens
5. Use of androgens.

Regarding surgical castration, suffice it to say that it may have a place in young women, but the harmful effects of premature castration must be counterbalanced with the good that can be accomplished.

There seems to be a type of carcinoma of the breast which needs estrogen for maintenance of its growth rate. As pure palliation, therefore, surgical castration is indicated here to eliminate most of the source of estrogen. If a relapse occurs months later, an adrenalectomy may be indicated as this removes another source of estrogen. If this fails, hypophysectomy may be done. Still later testosterone may be used to oppose an estrogen effect.

The nonestrogen-dependent cancers do not respond to the above therapies but do respond to estrogens, particularly in postmenopausal patients.

The better differentiated adenocarcinomas and the papillary carcinomas respond best to adrenalectomy, but the anaplastic lesions show no response to the procedure. A failure to respond to castration indicates a failure to respond to adrenalectomy. Thus, the adenocarcinomas and the papillary lesions may be the estrogen-dependent group, and in these the radical forms of palliation may be worth while.

We are not convinced that there is a place for adrenalectomy as yet, or even for the removal of the pituitary. We are convinced that some excellent palliation can be achieved by irradiation and/or hormones. We irradiate postoperatively all of our patients who have positive axillary nodes, although we are beginning to wonder whether it should be done in the immediate postoperative period or withheld until recurrences arise. There is much evidence accumulating that irradiation does not increase the percentage of five-year survivals, but there is also evidence that it decreases the number of local recurrences and thus theoretically increases the number of survivors.

We use androgens, with or without castration, in all premenopausal patients who show evidence of recurrence, particularly in the skeleton; and we use estrogens in postmenopausal patients who develop recurrences, realizing that the further past the menopause the patient is, the better the response to the estrogen will be. When a response occurs with the use of either hormone, there is objective improvement in that bony and soft tissue recurrences are less severe, and subjective improvement in that there is relief of pain, dyspnea, anorexia, and malaise, with a definite increase in a feeling of well-being.

One of the real objections to palliative therapy is that the patient realizes that her tumor is still present. This psychic trauma is tragic; it also occurs in those people who are denied surgery because of a positive internal mammary node. The patients simply cannot understand why their cancers have not been removed. They are resigned to an early death. Here, then, is an argument against the intercostal biopsies. Is it better to biopsy and refuse surgery if the node is positive? Or is it better to ignore the internal mammary group and do a radical mastectomy in all patients? I do not know the answer. Even though Haagensen feels that a radical mastectomy done for incurable disease shortens the patient's life, I cannot accept this belief. If the internal mammary nodes are negative, the radical operation should be done anyway. If the nodes are positive, I am forced to believe that a radical operation should be done regardless.

I am unable to refer a patient for palliative therapy with a lesion which is operable, except possibly a patient with a positive in-

ternal mammary node. So far, I have been unable to condemn a patient to the mental depression caused by the knowledge that I could do little or nothing for her. Most patients feel that they are cured by having had the radical operation. Isn't it better to let them think this even though their chances are actually remote, when we have not done any real harm by performing the operation?

Scholte of Holland has published his results with radical mastectomy and postoperative irradiation; these results are comparable to those in another group having routine supraclavicular and internal mammary node dissections. This seems to indicate that the more radical procedures are unnecessary.

The real question concerning cancer of the breast is why our operations fail so often, or why we fail to obtain a 100% cure in patients with a localized lesion and no evidence either clinically or pathologically of axillary spread. The only conclusion is that there is already spread of the cancer cells that we are unable to detect at the time of surgery, or perhaps some cells are spread during the operation.

McWhirter has aroused considerable interest as well as controversy by recommending a simple mastectomy followed by postoperative roentgen therapy. His idea is that if the axilla is not involved, there is no need to do a radical axillary dissection and that if the tumor has spread to the axilla, removal of this natural border, together with trauma inflicted on the involved tissues, may well allow dissemination of cancer cells to distant sites. He reports the five-year survival rates for all operable cases treated during a ten-year period. From 1941 to 1945, when his main method of treatment was simple mastectomy with postoperative x-ray therapy, he had 141 cases, with a 55.9% five-year survival rate. This figure was compared with a five-year survival rate of 44% among 569 cases treated by radical mastectomy plus x-ray during another five-year period.

McWhirter's views are so contrary to the teaching in this country that one would hesitate to adopt his method without further proof of its value.

Where, then, does radical mastectomy fall down? There is no agreement as to the amount of skin to be removed, the necessity for skin grafts, and the methods of undercutting the skin in a peripheral dissection. A study of five-year survival, in cases where disease is limited to the breast, fails to prove the contention of proponents of extreme undercutting with skin grafting that their method is superior. Because pathologists vary in their degree of thoroughness and accuracy and in their interpretations of what constitutes a Stage I case, and surgeons have different degrees of thoroughness in dissecting out axillary nodes, it is difficult to find a common basis for comparison on number of Stage I cases or on percentage of axillary involvement. Hence, statistics may be misleading though not intentionally inaccurate. The decreasing incidence of skin recurrence is dependent not on the variations in surgical technique, but on earlier diagnosis and surgical treatment and on the adherence to a more narrow incidence of operability.

Small and Dutton (University of Rochester) studied the data on 1,008 cases of carcinoma of the breast—all the cases seen at their hospital up to 1953. Assuming that every radical operation was an attempt to cure the patient and that nonradical procedures such as simple mastectomy, irradiation, or hormone therapy were used on the inoperable cases, they divided their series into two groups—those receiving radical treatment and those receiving nonradical treatment. Survival times were calculated from the date of operation to the date of death, or from the date of onset of treatment in the nonradical group. The patients in each class were grouped according to age, and survival at each year was compared with the normal survival in females of similar age who did not have cancer. These figures showed what we all know, that carcinoma of the breast in young women is often rapidly fatal, while in the aged woman the course is likely to be more benign. Among the older women survival lines of the groups receiving radical and nonradical treatment tended to approximate each other. These authors concluded: "When considered by itself, the radical mastectomy operation leaves much to be desired from the standpoint of long-term survivals. It appears that mortality from cancer is a constant process, little effected by treatment. Between 24–38% of patients with cancer behave as if cured with respect to mortality, regardless of the method of treatment. It is doubtful if many

more persons are cured by radical mastectomy than by other forms of treatment. In the cancerous groups as a whole, distribution of deaths is as if a few die at normal rates while the majority die at increased rates."

An even more pessimistic view is expressed by McKinnon (University of Toronto), who found that breast cancer mortality rates in Ontario had not declined but had held persistent levels despite an expanding program for control and many other factors conducive to earlier treatment. He cites this as proof of the failure of early treatment. In most cases of lethal breast cancer, remote spread by the blood stream takes place before treatment can be started, and McKinnon feels that consequently neither early nor extensive treatment of the primary lesion can effect any reduction in mortality. He also feels that the type of cancer determines the outcome in each instance. It is histologically impossible to differentiate remotely metastasizing, locally metastasizing, and nonmetastasizing types, and so survivals in Stage I groups are not reliable criteria for determining curability of breast cancer with any form of treatment. McKinnon feels that the early spread of cancer explains the similarity in survivals regardless of treatment, and that we must recognize that no effectual control of mortality from any major cancer has yet been achieved. We are not to assume, though, that cancer should not be treated. However, he pleads that we temper our claims for one form of treatment or another with understanding of the limitations of both diagnosis and treatment.

Kreyberg (Oslo) emphasizes that early diagnosis in breast cancer is supposed to establish a form of cancer that could theoretically be cured by a simple mastectomy; but since only half the tumors occurring in the population can be diagnosed early enough to be cured by present techniques, and since two-thirds of the tumors have already metastasized when diagnosed, it is possible to save only a relative few by surgery, irradiation, or both.

Gotch also recognizes the limitations of radical mastectomy for the cure of breast cancer, and states categorically that the results from early operation are no better than those from later operations. He also shows how variable is the course of breast cancer, and that since this cancer kills by metastases, the important question is what, if anything, operation does to prevent metastasis. There is much confusion regarding the best operation for breast cancer, but experience has shown that the Halsted operation is best for most cases. It gives a clinical cure lasting five years or longer in a considerable number of cases; permits perhaps 85% of all patients to die of internal metastases or intercurrent disease, without the affliction of an external growth; and does not cause serious deformity or disability. Gotch feels that the extension of the operation into the neck or chest is "worse than useless."

Meigs and his Boston co-workers have worked so diligently on detecting and treating cancer of the cervix that, while the mortality of all other cancers is increasing or holding steady, the mortality of cervical cancer is actually decreasing. Newer methods of detection, earlier diagnosis, and more uniform and consistent treatment are all factors in this improvement. As in the treatment of cancer of the breast, there is a controversy as to whether to use surgery or irradiation in treatment; but with the discovery of SR (sensitization response) and the identification of the typical cell found only in patients with cancer of the cervix and never in patients with a normal cervix, it became possible to tell beforehand which patient should be treated with surgery and which with irradiation. Meigs believes there is an immune response to cancer of the cervix in all patients, and there is certainly evidence that this might be true for all cancers. On examining the cells found in patients with cancer of the cervix, it is possible to tell which patients have a high or low SR and which patients have a high or low RR (radiation response). Treatment with surgery or irradiation is then carried out on the basis of these values. The mortality from cancer of the cervix has decreased steadily since this discovery.

It is not too much of a dream to believe that sooner or later we might be able to determine the SR in cancer of the breast. This would be better than all of the criteria we now use to determine the proper treatment. The problem became all the more enticing when it was found that we could change the SR and RR with hormones. After total irradiation of animals, it was found that testosterone increased the sensitivity to irradiation in females, and stilbestrol de-

creased it. Thus various combinations of hormones and x-ray therapy will improve the results from the treatment. Since cancer of the cervix, as well as cancer of the breast, is hormone susceptible, we may be on the threshold of better results in cancer of the breast, knowing these newer factors of utmost importance. It is also comforting to us as humans to know that if we are subjected to an atomic blast and the ensuing irradiation, our chances of survival might well be improved if we quickly consumed a quantity of testosterone to decrease the effect of the irradiation. Women, of course, would have to take stilbestrol.

It seems almost heretical for me, a surgeon, to question the over-all value of surgery in the treatment of cancer of the breast. No one in this country, as yet, is proposing that radical mastectomy be abandoned. Let me repeat my belief that it is still the treatment of choice in operable cancer of the breast; but in this year of 1955, surgeons cannot truthfully say that they are completely satisfied with the operation or its results. It is by far our best weapon to date, but let us not make unproved and unwarranted claims about the operation, particularly since we may be on the verge of discovering a far better form of therapy. Even though we may doubt the wisdom of the super radical operations for breast cancer, it will still be 5 to 10 years before they can be properly evaluated. It will be more decades before any newer treatment can be worked out and evaluated in a large group of patients. Let us, therefore, continue the effort; let chosen centers do the operation of their choice—radical or more radical—and prove or disprove their claims; let the surgeon, roentgenologist, physicist, and chemist continue their combined researches in cancer to lead the way for all of us; let the rest of us continue to do radical mastectomies to the best of our abilities, as early as possible, and with the finest of techniques. Then, who knows, one of these days some person or, more likely, some group will have the answer. Then, praise God, we will have reached the millenium in the treatment of cancer of the breast.

1200 East Broad Street.

SECTIONAL MEETING OF AMERICAN COLLEGE OF SURGEONS MILWAUKEE, FEBRUARY 27–29, 1956

All physicians are invited to attend the three-day sectional meeting of the American College of Surgeons to be held at the Hotel Schroeder, Milwaukee, from February 27 through February 29.

Among the topics to be considered are handling of mass casualties, fractures in children, hypothermia in cardiac and general surgery, carcinoma of the prostate, tumors of the thyroid, cancer of the colon, intestinal obstruction, problems in operability, operative versus medical treatment of diseases of the thyroid gland, endocrinology in gynecology, congenital defects of the head and neck, biliary tract surgery, and diverticulitis of the colon.

Special hospital clinics will be offered on Tuesday morning, February 28, at Milwaukee County Hospital and on Wednesday morning, February 29, at the Veterans Hospital.

Medical motion pictures and cine clinic films will also be included in the program.

Special luncheon meetings are planned for gynecologists and obstetricians and for ophthalmologists and otolaryngologists.

At a Tuesday evening dinner meeting, Dr. Paul C. Hawley, The Director, ACS, will give a brief report on the work of the College. Two films—"Big Game Hunt in British Columbia," personally made by Dr. R. V. Landis, Appleton, and "Danger at the Source," concerned with the problem of more support for the nation's medical schools—will be shown.

Wisconsin surgeons, including faculty members from Marquette University and the University of Wisconsin, will be assisted by such visiting talent as Brock E. Brush, Dwight E. Clark, Warren H. Cole, George Crile, Jr., Edwin H. Ellison, John B. Erich, Joseph P. Evans, Donald J. Ferguson, George H. Gardner, R. Kennedy Gilchrist, Frank Glenn, Samuel P. Harbison, James B. Hartgering, Charles C. Higgins, C. Paul Hodgkinson, N. Logan Leven, F. John Lewis, Charles W. McLaughlin, Jr., Samuel Meyer, H. Mason Morfit, Rudolf J. Noer, Bradley M. Patten, Ralph A. Reis, Harold G. Scheie, Joseph R. Shaeffer, Derrick Vail, John M. Waugh and Robert Bruce Wilson. Dr. Forrester Raine, Milwaukee, is chairman of the advisory committee on arrangements.

Treatment of Ligament Injuries of the Knee Joint*

By DON H. O'DONOGHUE, M. D.
Oklahoma City, Okla.

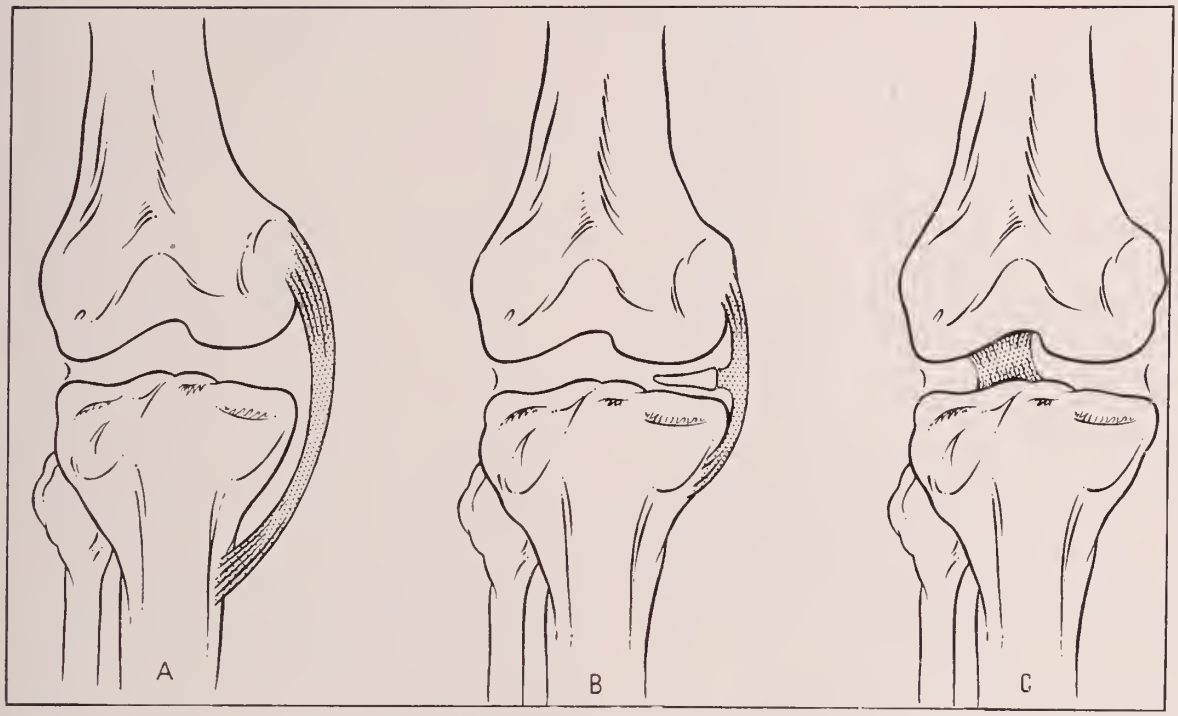

Fig. 1—Anatomy. (A) Superficial layer of medial collateral ligament; (B) Deep layer of medial collateral ligament plus medial cartilage; (C) Anterior cruciate ligament.

Introduction

IN ORDER to establish a proper premise for this discussion, it is necessary that the terminology which we are to use be defined and understood. It must be remembered that a ligament is a fibrous structure designed to prevent *abnormal* motion of a joint. Any injury to a ligament caused by abnormal motion may be defined as a sprain. It should be obvious, then, that a sprain can vary from a complete dislocation of a joint with total loss of integrity of a ligament, to a slight slipping or fragmenting of some elements of the ligament. Anatomically, it properly includes avulsion of the ligament from the bone, partial avulsion of the ligament from the bone, separation of the ligament fibers in a transverse manner, or slipping of the fibers of the ligament on themselves in such a way that the ligament becomes elongated and its function of preventing abnormal motion in the joint impaired. Since we are primarily concerned clinically with the function of the ligament, it matters little in what *way*, but a great deal to what *extent*, this function is disturbed. It becomes immediately apparent that the severity of the injury is of much more importance than the exact location or type of tear. So it follows that it is of prime importance to be able to determine the degree of loss of function of the involved ligament at the earliest possible moment.

Figure 1 will serve as a review of the ligamentous structures of the knee. It will be recalled that the knee consists essentially of two long bones meeting end to end with neither a deep ball and socket like the hip, nor a mortise and tenon like the ankle. A

* Presented at the One Hundred and Fourteenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, May 4, 1955.

great deal of the stability of the knee joint depends upon the intricately designed and ingeniously arranged ligaments of the knee. The lateral ligaments and the posterior ligament actually are a part of the great investiture of the joint on both sides and posteriorly by ligamentous structures which become thinned in front to become part of the patellar retinaculum and so permit motion at the joint. These ligaments are supported and their strength greatly augmented by the cruciate ligaments, which are very strong, fan-shaped structures, each twisted on itself to permit motion but to provide maximum stability. A detailed anatomical survey is not possible here. It suffices to say that these ligaments do act synergistically and serve to support each other in preventing abnormal mobility of the knee, while at the same time permitting normal motion. Clinically, the knee joint is a hinge joint, although anatomically its motion is much more complicated than that of the usual hinge joint. The ligaments of the joint are so designed as to prevent abnormal lateral motion, abnormal rotatory motion, and abnormal forward and backward motion. The heavy posterior ligament serves to prevent overextension of the joint.

Types of Injuries

With this brief anatomical survey, let us return to the subject at hand; namely, a ligament injury at the knee joint. The cause of a sprain is an abnormal motion of the joint which throws a stress on the ligament designed to prevent this motion. Forcing motion beyond its normal limit will result in some degree of injury to the ligament primarily involved. In the knee joint, this motion may be in any direction; it may be adduction or abduction, overextension, internal or external rotation, forward or backward displacement, or almost any combination of these, although certain particular combinations are much more frequent than others. Much depends upon an accurate diagnosis of the nature of the injury. Knowing the manner of injury certainly can give a lead as to the type of ligament damage to be expected. In one classical injury, the foot is fixed to the ground, the thigh rotates inward and the leg outward, the knee is forced inward toward the opposite leg, and the stress is primarily received on the ligaments on the inner side of the knee. This is by far the most common type of athletic injury of the knee. In this case, what may we expect in the way of injury provided it is known that the accident occurred by the familiar lateral blocking, or by the "cut back" motion of the running athlete? As the foot is forced into external rotation, stress comes against the medial collateral ligament of the knee, the superficial layer of which takes the strain first (Fig. 2a). As this layer stretches, tears, or gives way, the force reaches the deep layer, to which is attached the medial meniscus (Fig 2b). If the force continues, the anterior cruciate receives the stress, and it too may give way; in severe injuries, the posterior cruciate may also give way (Fig. 2c). Obviously, such injury may stop at any point in this progression of events.

In a similar manner, the adduction or internal rotation type of injury puts the force against the lateral ligament of the knee, the lateral cartilage, and the anterior and posterior cruciate ligaments. Likewise, hyperextension at the knee throws initial stress on the posterior ligament of the joint, followed by stress against the posterior cruciate ligament and the cartilages. Direct forward motion of the tibia on the femur will injure the anterior cruciate, while the opposite maneuver will damage the posterior cruciate. All too frequently an accurate and detailed description of the nature of the injury is not available. However, it is of considerable importance since it may give an early diagnostic lead.

Diagnosis and Treatment

From the standpoint of *diagnosis* of injury to the joint, what are the important factors to be considered? First, a general evaluation of the situation: Did it seem to be a serious injury? If the injury was sustained in athletics, was the player immediately disabled, or was he able to keep going? Did he feel that he had had a serious injury? Was he able to come off the field under his own power, or was he carried? Was he suffering extreme pain, or was it relatively mild? This general evaluation is, of course, subject to further modification following examination, but is ofttimes of considerable importance in determining the severity of the injury. Following this evaluation, an early, careful, and complete physical examination of the joint is of extreme importance. The earlier this can be done, the better, since there are

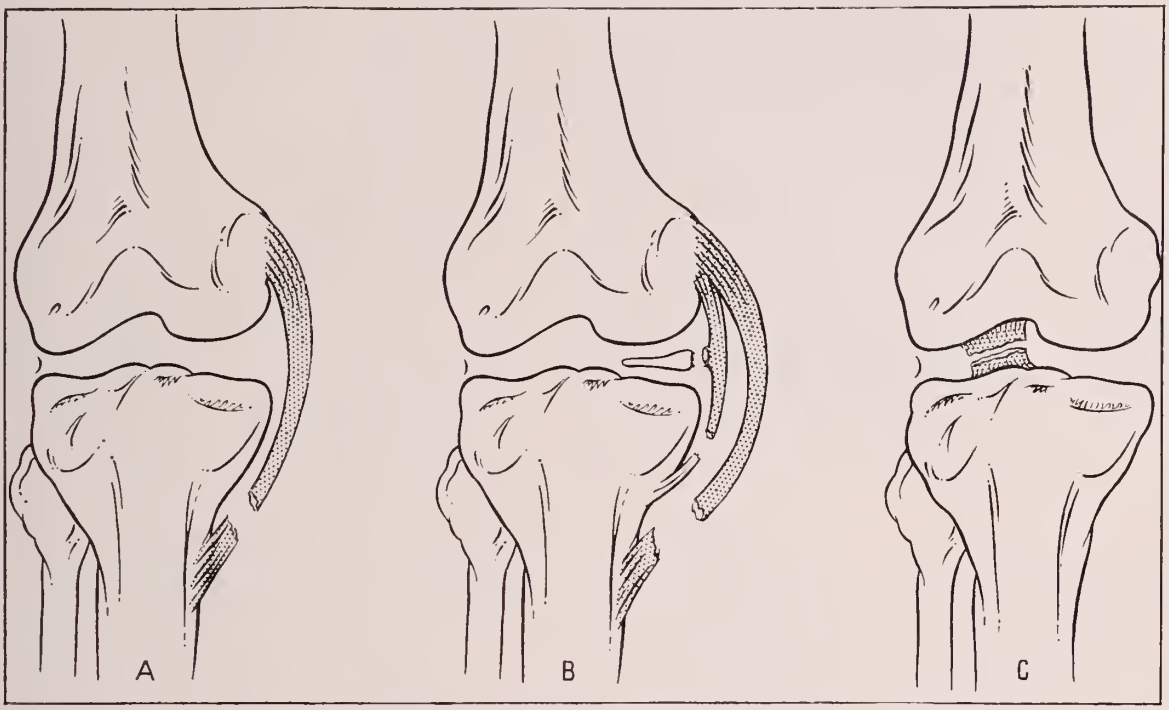

Fig. 2—Pathology. (A) Tear of superficial layer; (B) Tear of deep layer plus detached cartilage; (C) Tear of anterior cruciate.

often elements that can be noted at an early stage which become obscure after pain and swelling screen the symptoms. Note whether there is free motion of the joint through its normal range and if this is pain-free. Check carefully for tenderness about the joint and note accurately whether it is at the joint line, above the joint, or below. Check the knee carefully for abnormal mobility in all directions, noting rotation, lateral motion, and anterior and posterior motion. Observe the degree and rapidity of the swelling. Investigate whether the knee was actually locked at the time of injury, and whether it is actually locked at the time of the examination. All of these things are of extreme importance if they are done in this early stage before pain, swelling, and apprehension become factors. Many times a definitive diagnosis can be made in this initial examination, particularly with regard to the location and extent of ligament injury.

MILD INJURIES

Let us consider, then, the various degrees of ligament injury from the standpoint of diagnosis and treatment. The simplest classification of knee ligament injuries divides them into three general groups; namely, mild, moderate, and severe, descriptions which are pretty largely self-explanatory. Let us consider these groups in order of severity, beginning with the least severe. In a *mild* ligament injury, we postulate that there has been some tear in the ligament but that its strength has not been particularly impaired. There has been some degree of damage, either to the ligament itself or at one of its attachments. The symptoms of such a tear are tenderness at the site of the tear, pain on active use of the knee, local swelling at the site of the injury, and pain on forced motion or attempt to duplicate the motion which caused the tear. The findings which ordinarily would *not* be present in a mild injury are instability, blood in the joint, effusion in the joint, locking of the joint, and pain on ordinary motion of the joint. Provided that determination can be made of a mild injury, treatment can be based on the premise that the ligament is actually intact. This type of ligament injury does not require prolonged and extensive treatment; and, fortunately, it includes the great bulk of ligament injuries. The basis of treatment is rest, cold applications followed at a later time by heat, protection against further injury, and injection into

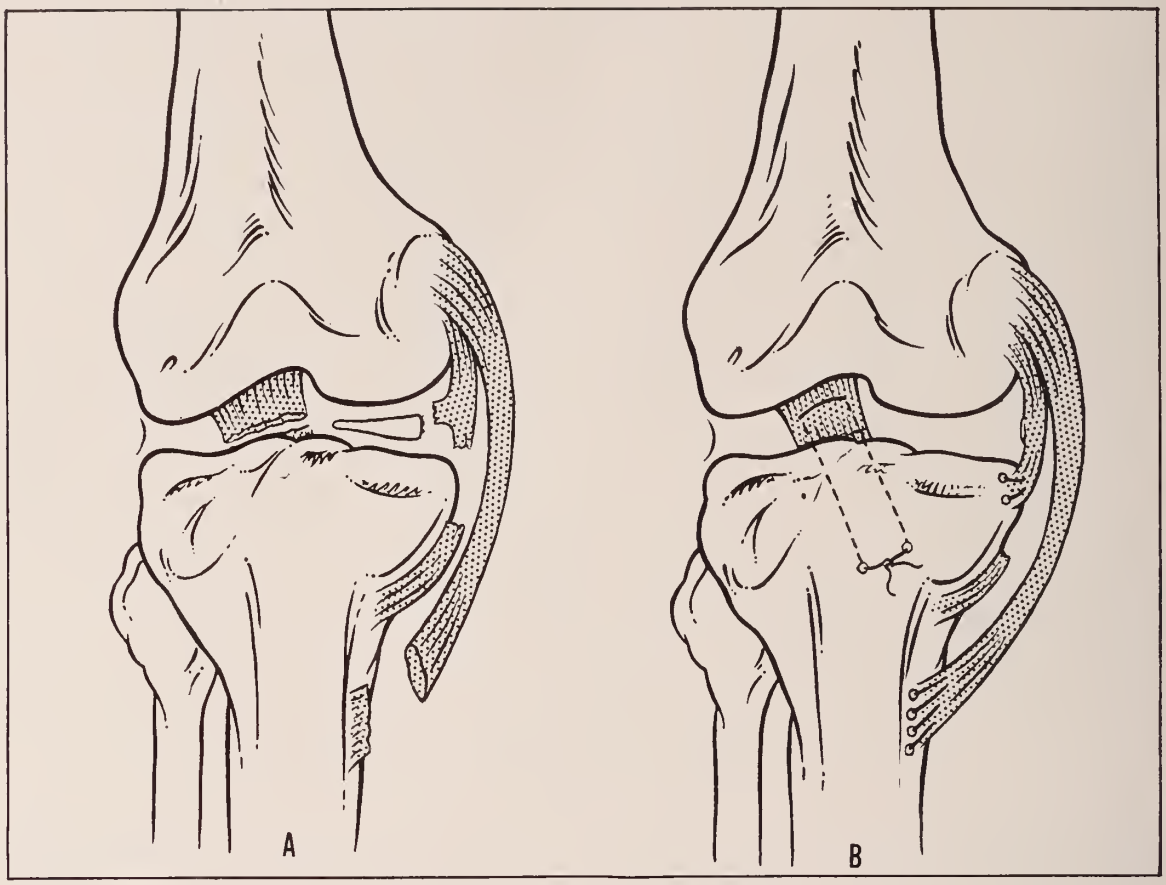

Fig. 3—(A) The injury; (B) The repair.

the involved ligament of such substances as Novocain, Diffusin, and Hydrocortone. With these injuries, activity can be resumed at once or at least relatively soon. Complete immobilization is neither necessary nor desirable. The patient may be rapidly rehabilitated without danger.

MODERATE INJURIES

In the second group of injuries, the *moderate* ligament injuries, it is visualized that the ligament has been partially torn, rather than just having had a few of its fibers pulled apart or separated. A certain definite portion of the ligament has been damaged. The symptoms in this group are very similar to those in the mild injury group and are greater only in degree; each group shades imperceptibly into the other. The positive findings are pain in the knee; tenderness at the site of injury; disability of a greater degree than that in the mild type of injury; swelling at first localized at the area of damage, later found diffusely in the joint; fluid or blood in the joint; and pain on reproduction of the force and direction of the injury. There may also be locking due to cartilage damage. The findings which are *not* present in a moderate injury are *excess* lateral motion and *positive* drawer sign. Each of these tests indicates complete avulsion of a ligament where abnormal motion is permitted; this should not be present if there is only partial damage to the ligament. The treatment in these circumstances is based upon the premise that there has actually been a significant damage to the ligament with weakening of its structure and considerable loss, or at least potential loss, of function. Therefore, it must be more comprehensive than that in the mild groups. Treatment consists of rest, cold packs early followed by heat, protection by splints, pressure dressing, aspiration of the joint, etc. This must be followed by a period of rehabilitation, which is necessary since there is a required period of immobilization during the course of treatment. In the rehabilitation, active physical

therapy, increase of active use of the affected part, protective strapping, re-education, etc., are all of considerable importance. This group of ligament injuries is the one where injudicious overuse or too early return to physical activity may cause recovery to be slow and incomplete. Reduction of pain and swelling by local injection must not be permitted to cover up the true nature of the injury since active stress must not be allowed until healing is complete. Ordinarily, recovery should be expected, with no residual disability in the joint. The major number of knee ligament injuries will fall into either the first or second group discussed above.

SEVERE INJURIES

In consideration of the third group, the *severe* ligament injuries, diagnosis is based on the premise that one or more of the major ligaments of the knee is completely torn loose from its attachment, or torn through its substance (Fig. 3). The mechanism of this injury is that previously mentioned; namely, forcing the knee through a wide range of abnormal motion beyond the tolerance of the ligament. The symptoms are much more severe in this type of injury than in the other types. There is ordinarily immediate disability, which is usually severe. There is the feeling that the knee has given away or dislocated. There is extreme pain at the time of injury. Examination and evaluation reveal immediate disability, giving away of the knee joint, severe pain in the knee and leg, definite abnormal motion (rotatory, lateral, or anterior-posterior), instability of the knee joint, blood in the joint, blood infiltrating through the tissues, local swelling first at the site of injury and then very rapidly into the knee itself, possible locking, and, confirmatory x-rays showing abnormal lateral motion at the knee joint (Fig. 4).

The treatment of this serious type of ligament injury is extremely important, and this is the field in which there has been considerable difference of opinion as to the best measures to be employed. Fortunately, this type of injury is not common; but when it does happen, it can be disabling to the point where an athletic career is abruptly terminated. Once the diagnosis of complete loss of integrity of one of the major ligaments of the knee has been made, it becomes imperative that some decision in regard to the necessary steps to be taken be made at once.

Fig. 4—Typical x-ray taken without patient being given anesthetic. (a) With the tibia in abduction; (b) With the tibia in neutral position.

Every effort should be made to determine accurately the structures involved. Are both layers of the medial collateral ligament torn? Is the anterior cruciate ligament intact? Has the posterior cruciate ligament been damaged? The physician should not take the attitude that he will "wait and see" what the degree of disability is following recovery and then attempt to determine definitive measures of treatment, since in this particular situation there is a very major difference between late reconstruction of a ligament and early repair. Ligaments in the knee joint are extremely complicated in their mechanism and cannot be replaced with any artificial substance to the extent where they have anything approaching normal function. On the other hand, following even very extensive tears, they can be repaired to the point where entirely normal function is obtained. So it becomes imperative that a decision be made during the early stage of the injury as to whether or not the ligament has been damaged to the extent that it needs repair.

It is my opinion that if it can be determined that there is actually a rupture of the medial collateral ligament, the anterior cruciate ligament, the posterior cruciate, or the lateral collateral ligament, such a condition should receive early, prompt, definitive surgical treatment in order to provide the maximum chance for complete recovery. Following major injuries, some patients have recovered apparently normally functioning knees without surgery. There is an occasional isolated case which has been reported as having regained "good function" follow-

ing complete dislocation of the knee. On analysis, most of these cases, however, have not gained what an athlete considers "good function"; he must have essentially normal ligament structures of the knee if he is to maintain his championship ability. If it is decided not to operate, then the treatment should be rest with adequate support, and cold followed by heat, after which there should be a long period of immobilization in a plaster cast with the knee in the position for maximum relaxation of the ligament involved. Then there must be a period of extensive physical therapy. Should surgery be indicated, a *complete* repair should be done, making great effort to repair the cruciate ligaments as well as the collateral ligaments. Regarding this, a misunderstanding has sometimes arisen and caused undue discouragement on the part of surgeons attempting the knee repair. Early repair of a torn cruciate ligament is an extremely successful and not too formidable procedure. Late reconstruction provides, at best, a poor substitute for the normal cruciate ligament. Failure to restore normal function in the cruciate ligament following *late* reconstruction should not be used as an argument against *early* repair, which may in many instances give normal function. If surgery is to be utilized in these major injuries, it should be done as a method of selection, not as a "last resort" after other measures have failed. I have seen many athletes return to championship careers following major ligament injuries to the knee which have been promptly and completely repaired. On the other hand, I have seen many a promising career nipped in the bud following apparently less major injuries in which there was procrastination and delay, or treatment by selective nonsurgical measures. It should be emphasized again that surgery is required in only a relatively small percentage of cases of knee ligament injuries. However, when it is indicated, it is of extreme importance that it be done promptly.

Summary

It is extremely important that there be early, thorough, careful, and repeated examination of ligament injuries of the knee joint. It should be performed in the following steps:

I. Careful history of character of injury and symptoms up to time of examination
II. Physical examination
   A. By visual means
      1. Note deformity
      2. Note swelling
      3. Note discoloration
   B. By palpation
      1. Note local heat
      2. Note tenderness
      3. Note presence of fluid
   C. By manipulation
      1. Note pain on normal motion
      2. Note pain on abnormal motion
      3. Note increased mobility, crepitation, etc.

Only after early, careful, complete examination with a definite decision as to the nature of injury and particularly as to the degree of the damage can we proceed with intelligent, adequate treatment of these ligament injuries to the knee in order to protect the athlete against permanent disability, diminish his period of temporary disability, and return him to full competition with no residual impairment, either mental or physical.

Lee at 10th Street.

(The illustrations in this article are reprinted, with permission, from the October, 1950, Journal of Bone and Joint Surgery. Part of the text material was formerly printed in Medical Records and Annals).

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY EXAMINATION

The next scheduled examination (Part I), written examination and review of case histories, for all candidates will be held in various cities of the United States, Canada, and military centers outside the continental United States on Friday, February 3, 1956.

Case Abstracts numbering 20 are to be sent by the candidate to the secretary, Robert L. Faulkner, M. D., 2105 Adelbert Road, Cleveland 6, Ohio, as soon as possible after receiving notification of eligibility to the Part I written examination.

Psychosomatic Aspects of Premenstrual Tension*

By HENRY VEIT, M. D.
Milwaukee

AT THE 1954 international meeting of physiologists at Montreal, one entire session was devoted to a review of recent experimental work on humoral and nervous mechanisms involved in emotions.[1] The pathways for response of the uterus to sensory stimuli and mechanisms for release of the antidiuretic hormone under emotional strain and in various phases of uterine activity were described. This symposium is an indication of the increasing attention physiologists and psychiatric workers are giving to the organic background for emotional disturbances.

The trend now is to emphasize the physiodynamic rather than the psychodynamic explanation for human behavior. While motivations may be explained in terms of psychodynamics, the causes that lie beyond motivations cannot be so stated. Failure to realize this has led to confusion as to what was pathology and what was etiology. The resistance of some illnesses to psychotherapeutic endeavors is in many instances due to abnormal biochemical reactions that are now only beginning to be understood.

The new developments in psychiatric treatment are based on organic concepts. The more widespread application of surgery for the correction of psychiatric defects is an example of this; and the continued search for drugs that affect moods and perceptions, the integrative function of the ego, the endocrine system, and metabolism in general as related to psychiatric disturbances also signifies this trend.

The elaboration of these new techniques makes correlation of somatic and psychological data of increasing importance in developing psychiatric insight.

With these thoughts in mind, I would like to discuss the problem of premenstrual tension from both the somatic and the psychological points of view.

The symptoms of premenstrual tension are edema; irritability; and emotional lability with depression, vasomotor instability, and headache. These symptoms in mild degree are experienced by well-adjusted individuals. It is only when they are severe and disabling that the patient needs psychiatric evaluation. Tensions frequently accompany unconscious ruminations that represent re-enactments of prepuberty fantasies. Preadolescence is the stage of defiance and independent urges. Aware of their limitations and feelings of insecurity, the young people are perplexed when subjected to aggressive promptings. Premenstrual symptoms are often an expression of the futility of the independence they feel and the anxiety associated with further development of physiologic forces. Much remains to be learned about the psychologic aspects of this syndrome. It is often met in psychiatric conditions, especially in hysterical personalities, and is usually related to masturbatory guilt.

In my clinical experience with psychiatric cases, I find premenstrual tension a factor needing attention frequently. Anxiety, fear reactions, and depressive episodes are invariably aggravated at this time. Various degrees of frigidity appear to be associated with the premenstrual period. In psychotherapy, these psychogenic symptoms as well as their physiological concomitants, are alleviated when the woman understands, accepts, and desires her feminine role. This is accomplished by "working through" in review her psychosexual development, helping her change her false concepts, and helping her adjust to what is possible for her in daily living. In many psychiatric patients, tolerance to discomfort appears lessened; and as the premenstrual period is "uncomfortable," in the past, sedatives, and now more recently, Thorazine, Meratran, and Rauwolfia serpentina preparations have found a place in general management. These later drugs still require further evaluation. Morton and Suarez-Murias[2] report that 30 to 40% of women regularly experience premenstrual tension. The psychiatric therapeutic ap-

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* From Department of Psychiatry, Marquette University School of Medicine, Milwaukee. Revised from a lecture given at Milwaukee Hospital, Milwaukee.

proach may range from superficial to intensive psychotherapy. The general practitioner or the attending specialist often may not deem referral to a psychiatrist necessary and may handle the problem satisfactorily himself. If referral is considered necessary but is not acceptable to the patient, the physician must cope with the situation as best he can.

Williams and Weekes[3] call attention to psychotic episodes that sometimes are associated with premenstrual tension. They find that these episodes fall into three groups which may resemble (a) the catatonic form of schizophrenia, (b) manic depressive psychosis with a predominantly manic pattern, and (c) both catatonic and manic symptoms alternating in the same patient.

The dynamics of premenstrual depression involve conflicts about the feminine role and subsequent feelings of inferiority, frustration, disappointment, aggression, and guilt. The well-adjusted girl may have conflicts about accepting the female role, but she is able to cope with them. This suggests that the psychological constellation alone cannot explain premenstrual depression. One cannot infer from certain unconscious conflicts a disease entirely. These conflicts may be present in persons without any pathological symptomatology.

Premenstrual depressions have an endocrine background. Frank[4] found evidence of disturbed estrogen metabolism in 15 patients with premenstrual tension and concluded from the high blood and low urine estrogen values that a high renal threshold for this substance is characteristic of the condition. The effect of excessive amounts of estrogens on the nervous system is believed to be one factor in the production of symptoms. Frank postulated that the continued circulation of an excessive amount of female sex hormone in the blood may in labile persons produce serious symptoms, some cardiovascular, but the most striking definitely autonomic and emotional. In severe cases, even roentgen therapy was used to produce either temporary or permanent amenorrhea. Failure of the liver to inactivate estrogen, owing to a deficiency of Vitamin B complex, may be another factor. Some women retain sodium and water during the premenstrual phase as a result of cyclic ovarian activity.

Retention of sodium is associated with an increase in extracellular fluid. The resultant swelling of the tissues gives rise to symptoms; edema of the intestine produces nausea and vomiting, edema of the brain causes migraine, and edema of the vulva, pruritis and swelling.

Greenhill and Freed[5] advocate ammonium chloride therapy for relief of such symptoms. Greenblatt[6] recently also suggested such diuretics as Diamox, 250 mg. four times a day, and Neo-Bromth, two tablets four times daily, when premenstrual edema is the great factor.

Morton[2] considers premenstrual tension as a complex syndrome in which several mechanisms play a part. He recommends Pre-Mens, which includes ammonium chloride to relieve water retention symptoms, homatropine methylbromide to lessen nervous tension by its anticholinergic action, caffeine to combat sluggishness and depression, and Vitamin B complex for its corrective effects on both hyperestrogenemia and hypoglycemia. He emphasizes that in a small percentage of refractory cases, hormones such as progesterone, testosterone, or chorionic gonadotropin may also be given. Much of the above information became public knowledge in the article titled "Pre-Menstrual Tension: The Needless Misery,"[7] which appeared in the May, 1955, issue of *Reader's Digest*. Fortunately, the writer stresses premenstrual tension as an "individual problem," with the endocrine, physiologic, and psychogenic approaches mentioned.

The literature generally suggests that some cases of postpartum depressive psychoses are caused by a sudden drop in the high level of progesterone maintained by the placenta prior to delivery. Most authorities agree that women with neurovegatative instability are prone to develop the syndrome. Gillman[8] calls attention to the possible role of individual sensitivity to hormones. From the multitude of reports it can be concluded that, in general, disturbances of estrogen and/or progesterone metabolism and of water balance are etiological factors in premenstrual tension. According to Freed[9] the treatment of mild types of premenstrual tension consists of correcting the abnormal mechanisms of the syndrome by use of progesterone and androgen to neutralize excess estrogen, Vita-

min B to permit normal destruction of estrogen, and ammonium chloride to reduce sodium retention produced by estrogen.

For the severe depressions and those associated with psychotic episodes, Williams and Weekes[3] found that progesterone in doses of 10 mg. three times a day, ammonium chloride, sodium restriction, and electric shock gave the best results.

From the foregoing discussion, one can readily realize that, as Grinker[1] says, there should be an abandonment of the mechanistic concept, whether this be neural or humoral, and consideration that the basic unit of action is a cyclic process of varying rate and extent. Hence, for the individual, therapy is variable, depending upon the observed and known factors involved in the nervous, endocrinological, somatic, ideational, and emotional processes involved in transactional relationships.

2212 West State Street.

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THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY MEETING

The nineteenth annual meeting of the New Orleans Graduate Medical Assembly will be held February 27, 28, 29 and March 1, with headquarters at the Municipal Auditorium.

Eighteen outstanding guest speakers will participate, and their presentations will be of interest to both specialists and general practitioners. The program will include 54 informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, color television, medical motion pictures, round-table luncheons, and technical exhibits.

The Assembly has planned another interesting postclinical tour to follow the 1956 meeting in New Orleans. On Friday, March 2, a party composed of doctors and their families will leave New Orleans for the West Indies and Central America via plane. The itinerary includes Puerto Rico, St. Thomas, Haiti, Jamaica, Panama, and Guatemala; and arrangements have been made for medical programs in the places visited.

Details of the New Orleans meeting and the postclinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.

Funds Available for Hospital Out-Patient Facilities and Nursing Homes

As It Looks to Your State Board of Health

RECENT amendments to the Hill–Burton Act (federal grants-in-aid program for hospital surveys, planning, and construction) have made possible in a small way assistance in the construction of much-needed nursing homes and for out-patient departments of hospitals, with special consideration to be given to such projects in high priority areas as are established in connection with existing general hospitals. Specifically, federal aid in the amount of $200,000 is now available for diagnostic or diagnostic and treatment facilities in out-patient departments, and $130,000 has been set aside for nursing homes. Federal funds are to be matched with local community funds on a basis yet to be determined (probably at approximately the same ratio as for general hospital beds, or 40% federal and 60% local). While the deadline has not been set for applications, every interested person or organization in communities eligible for such financial aids will be notified as to position on the priority list.

The type of facilities contemplated will make it possible, through expansion of existing hospital out-patient departments, for medical specialists and technical personnel to work together as a team and to provide such services as are not now available in a given medical-hospital service trading area. Close cooperation with county medical societies will be of paramount importance in determining the extent of diagnostic or diagnostic and treatment services available and the need for additional services on the local area basis. In many instances, the primary need might well be additional and more adequate diagnostic and treatment equipment or the provision of additional work space where adequate equipment is already available in the out-patient department.

A nursing home is defined as a facility which is operated in connection with a hospital, or in which skilled nursing care and medical services are prescribed by or performed under the general direction of persons licensed to practice medicine and surgery in the state. It is primarily for the accommodation, on a community service basis, of convalescents or other persons who are not acutely ill and not in need of hospital care, but who do require skilled nursing care and related medical services.

Skilled nursing care must embody services and procedures which require technical knowledge and skills that can be provided only by professional registered nurses. Domiciliary homes which provide only personal services such as help in walking and getting in and out of bed, assistance with bathing, help in dressing and feeding, preparation of special diets, supervision over medications which can be self-administered, and other items of this order do not come within the definition of a nursing home, even though there might be available *temporarily* and *incidentally* the same type of limited medical attention as the individual would normally receive if he were living in a private home.

The State Board of Health is now developing a state-wide plan for these and other hospital facilities which, upon completion and approval by the Advisory Hospital Council, will be opened for pubic hearing and then submitted for final approval of the Board of Health and the Surgeon General of the Public Health Service.—VINCENT F. OTIS, *Director, Division of Hospital and Related Services.*

Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

Editor—DOROTHY W. BETLACH, M. D., Janesville, Wisconsin

Endotracheal Anesthesia*

Use of endotracheal anesthesia is one of the greatest aids at the command of the anesthesiologist. The development of this technique has increased the patient's safety, made possible many advances in surgical procedures, and made the anesthesiologist master of the mechanical aspects of respiratory exchange.[1] Extensive thoracic operations; plastic reconstructions of the face; and ear, nose, and throat operations are only a few of the cases where practical application can be made. The use of endotracheal anesthesia as a resuscitative measure in emergency situations such as drowning, asphyxiation, respiratory arrest or depression, and obstruction is invaluable.

Endotracheal intubation should be available to any patient who may benefit from it. However, it should not be used without good reason. Special training, skill, experience, and good judgment are essential requirements in the person applying it. Anesthesiologists should be adept in laryngoscopy and by practice and constant effort should develop flawless technique in its use. All medical men, too, should be sufficiently familiar with the technique of laryngoscopy to be able to use intubation in emergency situations. The ability to keep out of difficulty is of much greater value than the power to make a recovery from the difficulty.

Complications

Occasional complications and sequelae do occur with the administration of endotracheal anesthesia. These may be classified as mechanical, traumatic, and infective complications.

Mechanical Complications. Intubation is no guarantee that respiratory obstruction cannot occur. The patient and the apparatus must be under constant supervision. Most serious of these mechanical complications is the aspiration of foreign fluids. Cuffed tubes or pharyngeal packs help prevent inspiration of fluid regurgitated by the alimentary tract or of blood which may be in the pharynx. Other difficulties are kinking of the tube in the pharynx or nasal fossa, biting of the tube by a lightly anesthetized patient, and separation of the connector piece from the tube.

Traumatic sequelae include tracheitis; laryngitis; pharyngitis; rhinitis; and mechanical damage to the teeth, nose, pharynx, or larynx. These occur immediately or within the first 48 hours after anesthesia administration. Acute edema of the glottis is the most serious complication and is seen more frequently in infants and children than in older patients. Sequelae that occur from a few days to six months after the procedure include ulceration and granuloma formation.

Infective complications that occur postoperatively include pneumonia, acute bronchitis, empyema, and pulmonary abscess. It is difficult, however, to ascertain the percentage of complications due directly to the intubation technique. Postoperative records may contain incomplete information. Many of the infective complications are common among patients in poor physical condition, especially those with poor oral hygiene, and after certain types of operations in which endotracheal anesthesia was not used. Almost all the sequelae of endotracheal anesthesia are the direct result of a lack of skill in the management of the method. No evidence is available that endotracheal anesthesia increases the incidence of the major respiratory complications in the postoperative period.

Case Reports

Several cases illustrating physiological and mechanical difficulties which may be encountered are presented by the Wisconsin Anesthesia Study Commission.

Case 16. A dorsolumbar laminectomy and exploration of the spinal cord was performed

* Guest Contributor, Wilson S. Phillips, M. D., Milwaukee.

on a 24-year-old white male who was paraplegic following a crushing injury to the dorsal spine. Induction was with an intravenous injection of 300 mg. 2½% Sodium Pentothal, chosen by the anesthesiologist because the surgeon planned to use the electrocautery. Anesthesia was maintained with chloroform vaporized by a mixture of 3½ liters oxygen and 7 liters nitrous oxide gas flow per minute. During induction the patient was intubated, with the aid of a laryngoscope, with a No. 9 Magill nasal endotracheal tube. Passage of the tube through the right nostril caused epistaxis which did not seem severe at the time. After intubation the patient was placed in the prone position, and sponge rubber props were put under the shoulders and hips so that there was no mechanical obstruction to an adequate respiratory excursion. About 30 minutes after intubation, it was noticed that the patient's breathing had a peculiar coarse quality although there was no gross evidence of obstruction or mucus accumulation in the tracheobronchial tree. There was good excursion of the semiclosed reservoir bag, and the respiratory movements were adequate. An oral pharyngeal airway was inserted. There was considerable breathing through the airway, and respirations were more quiet and seemed more normal. Since the patient was obviously breathing around the tube and there was some doubt about whether the endotracheal tube was patent, the latter tube was removed. The distal opening of the tube was almost completely occluded with a blood clot which had been obstructing free passage of respiratory gases and the anesthetic mixture. The oropharyngeal airway was left in place and satisfactory anesthesia maintained with a semiclosed system.

Epistaxis is a fairly frequent complication of nasal intubation. It can be minimized by adequate lubrication of the tube and by careful technique of passing the endotracheal tube straight back along the floor of the nasopharynx rather than upward with undue force. Obstruction can occur even though respiratory exchange appears to be adequate. Whenever artificial airways are inserted, it is well to check them frequently for patency. One can never assume that an endotracheal tube insures an adequate airway. It may become blocked or kinked very easily and is then a real liability instead of an asset.

Case 0357. This patient was scheduled for partial gastrectomy for possible carcinoma of the pylorus with obstruction. The general physical condition was good. A Wangensteen stomach tube was in place at the time of anesthetic induction with Pentothal. Maintenance of anesthesia was accomplished with a mixture of cyclopropane and ether. A No. 35 Magill endotracheal tube was inserted without difficulty and the pharynx packed with moistened gauze. Respirations were manually assisted and, since there was excessive leaking through the pack, a second pack was placed in the throat. There was still too much leakage for adequate manual respiration, and both packs were removed. These were bloody. The endotracheal tube was replaced with a No. 35 Magill tube with a cuff which was inflated. The packs were in place 28 minutes.

Because of the known trauma, steam inhalations were begun postoperatively and continued for three days. The patient complained more of throat discomfort than of any pain from the surgical site. Inspection of his throat revealed the entire soft palate to be indurated and gray, resembling a postoperative tonsil fossa. Complete recovery occurred without sloughing.

* * *

Case 0358. A 35-year-old white female received 15 mg. morphine and 0.6 mg. scopolamine in preparation for a tonsillectomy to be performed with the patient sitting upright in a dental chair. Induction of anesthesia was accomplished with nitrous oxide and oxygen, and the patient was easily intubated with a well-lubricated endotracheal tube via the nasal route. The tube did not have an adaptor attached to the free end protruding from the nose. Anesthesia was continued with a face mask while the anesthetist selected an adaptor for the endotracheal tube. When the mask was removed, the endotracheal tube had disappeared. The patient's mouth was opened and a laryngoscope inserted. About one inch of the tube was seen protruding from the larynx. The end was seized with a forceps, the tube was withdrawn, and an adaptor attached before inserting the tube nasally again. This incident emphasizes the ease with which a well-lubricated tube may pass beyond the opening of the larynx, and the importance of attaching a tight-fitting adaptor to the

upper end of the tube to prevent such a mishap.

The advantages of endotracheal anesthesia are freedom of airway, control of intrapulmonic pressure, and ease of artificial ventilation. As long as the endotracheal tube remains patent, respiratory exchange should be efficient. In any procedure where patency is likely to be threatened by position of the patient or the surgical team, intubation is essential.[2] The technique is indicated in operations about the head and neck. Intubation is necessary also for thoracic operations, especially when controlled respiration is desirable and reinflation of the lungs is necessary. Certain abdominal operations, especially section for intestinal obstruction where regurgitation is likely to occur, are safer with endotracheal anesthesia.

It is important that anesthesiologists know how to keep the natural airway open by appropriate positioning of the patient's head or holding forward of the jaw. Free breathing can be safeguarded during general anesthesia by such simple means. Constant and indiscriminate use of endotracheal tubes is unjustifiable. The disadvantages of the technique are all mechanical. They are inherent either in the act of intubation itself or in the management of the method when the tube is in place. Almost all the sequelae are the direct result of lack of skill. Disadvantages must be emphasized to keep the anesthesiologist and the surgeon from being lulled into a false sense of security.[3]

"The modern devotion to Science, which is exact, as opposed to Art, which is not exact, has one disastrous consequence when applied to the practice of medicine. The devotees of the 'scientific' attitude are wont to seek 'indications' and 'contra-indications' and to apply them by rule of thumb to all patients who exhibit certain symptoms or signs. 'Routine' should have no place in medicine, for all 'indications' and 'contra-indications' are relative rather than absolute. Each case is a problem in itself, and must be so considered. Of nothing is this more true than of endotracheal anesthesia."[1]

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1956 POSTGRADUATE COURSES, UNIVERSITY OF MICHIGAN

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Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: Paul C. Dietz, M. D.

REPORT OF A CASE*

Dr. J. J. DuBois (Intern): The patient, a 48-year-old housewife, when first admitted, stated she had noticed a mass in the right breast for several weeks. One year prior to admission she had accidentally struck the right anterior chest wall against the protruding handle of a washing machine. The dependent portion of the right breast had remained tender for a month, and one month prior to admission soreness had again developed in this breast near the lateral border. Shortly thereafter the patient had become aware of a mass in this portion of the right breast. There had been no discharge from the nipple. She had had six pregnancies, resulting in normal children, all being breast fed. Menses had become irregular in incidence and quantity one year previously and now were scanty and at three-month intervals. A systemic review was nonrevealing in other respects. The patient had had no serious illness and no operations. She was of Irish extraction. Her father had died of cancer of the stomach and her mother of "cancer of the liver."

At physical examination her oral temperature was 98.6 F., the pulse rate 96, the respiratory rate 20, and the blood pressure 160/90. The patient was obese. No abnormalities of eyes, ears, nose, throat, neck, lungs, abdomen, or extremities were noted. The heart was slightly enlarged to the left, the rhythm being regular. The second aortic sound was accentuated, and a soft blowing murmur was heard over the apex. In the superior lateral quadrant of the right breast was a nontender, firm mass, approximately 3 cm. in diameter, attached posteriorly and fixed to the undersurface of the skin. The overlying skin was normal in appearance, and no axillary or paraclavicular lymph nodes could be palpated.

The red blood cell count was 4,150,000 and the hemoglobin 11.6 gm./100 ml. The white blood cell count was 10,550 with a normal differential count. A blood Kahn test was negative. The urine had a specific gravity of 1.025 and contained a trace of albumin; the sediment contained 5 white blood cells and an occasional red blood cell per high power field. An x-ray film of the chest was declared normal.

Biopsy of the right breast lesion revealed an anaplastic infiltrating duct carcinoma with fibrosis. Immediately, radical right mastectomy, with removal of the pectoral muscles and an axillary dissection was done. The specimen revealed metastasis of the tumor to the axillary lymph nodes, including six nodes in the apex of the axillary mass. Seventy-two hours after the operation edema of the right axillary and supraclavicular area and of the arm to the elbow developed and continued to be present thereafter. The wound healed rapidly. After five weeks 200 r were given daily for eight days to each of four 10 by 10 cm. ports: (1) the anterior and (2) the posterior supraclavicular area (3) the area over the anterior and (4) over the posterior axillary folds. The same dosage was given to a fifth port 20 by 20 cm., over the right anterior thorax. There was no overlap. After three months 200 r were given daily for seven successive days to a 15 by 15 cm. port over and anterior to the right shoulder and to another such port posterior to the shoulder. The factors employed were 220 kv., 50 cm. distance, and 0.5 mm. Cu and 1.0 mm. Al filtration. Chest x-ray examination at three months was negative for metastasis. A dull, aching pain in the right humeral and axillary regions was severe and almost constant, beginning during the second month postoperatively. After the sixth postoperative month the skin of the arm to the elbow became leathery, and the patient was able to move the arm at the shoulder only slightly and with pain. Physiotherapy was instituted and resulted in lessening of pain and disappearance of subcutaneous induration in the supraclavicular and axillary regions but did not influence the edema and induration of the

* From St. Francis Hospital, La Crosse.

brachial and distal tissues. Eleven months postoperatively chest x-rays disclosed pulmonary fibrosis on the right.

The patient continued thus for three years postoperatively, when x-rays of the right scapula, taken because of more severe pain and tenderness, revealed minute alternating osteogenic and osteolytic areas in this bone along its vertebral border and in the second right rib anteriorly. The spine was negative. A spontaneous fracture of the third right rib in the axillary line developed shortly thereafter, but it had healed with excellent union 10 months later. No progression of the bone changes in the scapula and second rib was noted in subsequent x-rays. Five years postoperatively the red blood cell count was 4,700,000 and the hemoglobin 13.7 gm./100 ml. The white blood cell count was 9,500, with 66% segmented cells, 17% band forms, 11% lymphocytes, 2% monocytes, 3% eosinophils and 1% basophils. Edema and induration of the right arm now extended to the finger tips, and in diameter this extremity measured twice that of the normal left arm. Tenderness was absent, except over the right humeral head. There was no paresthesia and anesthesia of the right arm, although motion was limited to five degrees extension and abduction at the shoulder, and movement of the fingers had become impossible. Pain was almost constant in the right shoulder except when the extremity was supported, and this pain was not influenced by testosterone.

No further change occurred in the right arm until the seventh year postoperatively, when the circumference at midhumerus was 46 cm., at midforearm 45 cm., and at the wrist 32 cm. The palm was 6 to 8 cm. thick, and the fingers tapered from a proximal circumference of 11.5 cm. to an almost normal circumference at the tips. The skin was indurated, leathery, and pink-gray and had a normal hair distribution. In the skin of the brachial region of the right arm were several dozen discrete and confluent, glistening, blue-red, slightly elevated, papular areas as large as 2 cm. but more often 1 to 3 mm. in diameter, from some of which oozed a serohemorrhagic fluid. These lesions covered approximately three-fourths of the circumference of the arm above the elbow but were most pronounced over the deltoid muscle. They were not found elsewhere upon the body. There was tenderness to light pressure over the head of the humerus in its superior and lateral aspects. A pathologic fracture of the right humerus was present in its superior one-third. The site of the right breast amputation was not unusual in appearance. A chest x-ray revealed no pulmonary metastasis. There had been recent dyspnea on exertion but no loss of appetite, and the patient had gained 15 pounds during the preceding 12 months. The red and white blood cell counts and the hemoglobin level were normal. The right arm was disarticulated at the shoulder joint.

Dr. A. G. Britt: This patient had a cancer of the right breast which was treated by customary right radical mastectomy, and for seven years thereafter she had edema of the right upper extremity. Then some unusual lesions appeared in the skin of that arm, and the arm was amputated. We are not informed that she succumbed to the disease or diseases. I think the discussion should be concerned with those facts.

The edema of the arm developed almost immediately after the breast operation and apparently became more disabling as time went on. A slight degree of edema of the ipsolateral arm is fairly common following radical mastectomy; but when the arm becomes swollen to the fingers and so markedly that it is useless and is a source of constant pain, that is uncommon. In cases such as this the surgeon always asks himself: "Why did this edema develop?" The fundamental cause is undoubtedly related to obstruction or distortion of the lymphatic channels along the course of the axillary and subclavian veins or of the veins themselves. Why some patients develop this unfortunate complication of radical mastectomy and others do not and why some develop it to a greater degree than others has never been adequately explained. This patient is said not to have had gross infection of the mastectomy site; but had she had such an infection, one might have ascribed her lymphedema to it. She received postoperative irradiation after the onset of the edema, and therefore we cannot attribute the edema to the x-ray. Certain technical aspects of the original operation sometimes thought to be causative in the production of postmastectomy lymphedema—such as the extent of the excision of the pectoral muscles, location of the incision and its scar,

injury to the axillary vein, and late mobilization of the arm—are not reported to us.

The problem in this case is one of explaining not only the edema but also the peculiar lesions in the skin which developed late. One wonders whether both could have been manifestations of metastasis from the original carcinoma of the breast. The fact that the axillary lymph nodes were involved would lead one to believe that this patient was susceptible to extended metastasis. The persistence of pain in the right shoulder region lends support to this possibility. The radiologic changes in bones of the right thorax which were noted three years after the operation must also be somehow explained. If they were due to metastasis, then our problem is simplified. Doctor Hulick, do you have an opinion regarding the nature of these osteogenic and osteolytic changes in the right scapula and second rib?

Dr. P. V. Hulick: I do not consider these changes as necessarily typifying those produced by metastatic tumor of the breast. It is more likely that they may represent an effect of irradiation on bone. I should add that I did not administer the x-ray therapy to this patient except for that given after her arm had been amputated. The initial dosage she received was adequate. It was enough to have caused some reaction in bone.

Doctor Britt: The patient survived for at least four years after the x-ray changes in bones were first apparent, and during this time no progression of these bone lesions occurred and no similar lesions appeared in other bones. These are fairly good reasons to doubt that the lesions were due to metastatic breast cancer. I am very much impressed with the survival of this patient for at least seven years in spite of all her troubles. I am going to assume, therefore, that these x-ray changes do not represent metastasis to bone from the breast cancer and that, in fact, metastasis from the breast cancer was not present at all beyond the axilla. The fracture of the right humerus, which occurred rather late, can be explained as the result of osteoporosis due to inactivity of the extremity as well as its elephantiac weight. The nodular, purple-red weeping lesions in the skin of the right shoulder and brachium are of great interest and no doubt of great significance. Could they have represented a recurrence of the original breast carcinoma? That is a distinct possibility, but their description and location argue somewhat against such an explanation. Carcinoma of the breast usually metastasizes centripetally and not in centrifugal fashion. Furthermore, the patient had gained in weight. The very description of the lesions is not typical of that of carcinomatous spread to the skin.

There are primary diseases and especially neoplasms of the skin which are not unlike those described on the upper part of this patient's arm. Melanocarcinoma is not likely to develop such wide spread in the skin without warning from a primary nevus, and we are not told anything about a pre-existing nevus on the right upper extremity. Mycosis fungoides is not a likely diagnosis since we are not told of an eczematoid stage preceding the colorful elevated lesions. I do not know how we can completely exclude dermatofibrosarcoma protuberans and Spiegler-Fendt sarcoid from consideration. One thinks also of Kaposi's multiple idiopathic hemorrhagic sarcoma. In that condition the lesions are elevated and red-blue; and they increase in size, finally becoming blue-black, more elevated, and diffuse. But Kaposi's disease is usually symmetrical and involves both hands or both feet, and preferably the feet. In our patient only one extremity, namely, an upper extremity, and this corresponding to the side of former mastectomy, was involved. Furthermore, the majority of cases of Kaposi's disease have occurred in Russian, Polish, and Italian people, while this patient was of Irish extraction. Kaposi's disease afflicts males far more often than females and is accompanied by visceral lesions in its advanced stages. When elephantiasis occurs in Kaposi's disease, it follows rather than precedes the nodular infiltration. One would not expect a patient with Kaposi's disease in the stage of tumor to gain weight. I would not like to exclude the diagnosis of Kaposi's sarcoma completely, however, since patients with that condition have survived many years when treated. Other angiosarcomata and hemangioendotheliomata also occur in the skin and must be considered as possible diagnoses; but these generally occur in a younger age group than that of our patient, although they do occur equally in the two sexes.

Figure 1

I continue to be reminded of the fact that in this patient under discussion we have the feature of postmastectomy lymphedema of the arm and that it was upon this extremity that these spreading, blue-red, elevated lesions developed. I saw a case similar to this some years ago during my residency, and it recalled then just as this case does now the article by Stewart and Treves in the first volume of the journal *Cancer*. In this article the authors described 6 cases of an up-to-then unreported sequel of postmastectomy lymphedema of the arm which they called lymphangiosarcoma. This sarcoma, involving the arm on the side of former mastectomy, began as isolated purple-red macules and gradually acquired satellites in centrifugal fashion, the lesions finally becoming confluent, larger, and elevated and acquiring a bullous, ulcerating surface from which a serosanguineous exudate ran. Such lesions developed 6 to 24 years after the mastectomy, even though the lymphedema had been present since the breast operation. Stewart and Treves did not believe the entity was necessarily related to carcinoma of the breast since 1 of their 6 cases had undergone mastectomy for a breast lesion which was thought to be malignant without biopsy, but which later was identified as benign. Neither did they favor the thought that x-ray therapy was of etiologic significance since some of their patients with lymphangiosarcoma had received none. That this skin change, following on the heels of postmastectomy lymphedema, is a malignant neoplasm was proved by the fact that it metastasized to intrathoracic organs in spite of attempts to control it by means of irradiation and even forequarter amputation. Stewart and Treves ventured the opinion that this unusual but serious sequel of a fairly common complication of mastectomy must have occurred many times in the past but that it had been misdiagnosed and had gone unrecognized as an entity deserving of special designation. I believe, then, that this patient we are discussing did have such a lymphangiosarcoma of the arm upon her postmastectomy lymphedema. It seems unlikely to me that a surgeon would amputate an arm as did this patient's surgeon if he thought the lesions on it were metastasis from a breast cancer. To be sure, this patient may have had metastasis from the breast cancer to some parts of her body; but I believe the lesions upon her right arm and shoulder were not metastatic from the breast.

Dr. P. C. Dietz: The gross surgical specimen (Fig. 1), the right upper extremity, was pachydermatous. Slight pitting edema was present over the dorsum of the hand, and there were deep transverse wrinkles and creases over the forearm. The skin was more indurated over the humeral portion than elsewhere and in this portion of the skin were myriads of blue, purple and red, discrete and confluent, macular and papular lesions, which, where they were isolated, were 0.8 to 2 cm. in diameter and were elevated a maximum of 1 cm. Toward the shoulder, over the lateral and anterior aspects, these became more numerous, slightly papillary, glistening, and firm; and some had recently become denuded and exuded a red serous fluid. Some were actually in the form of superficial hemorrhagic cysts up to 1 cm.

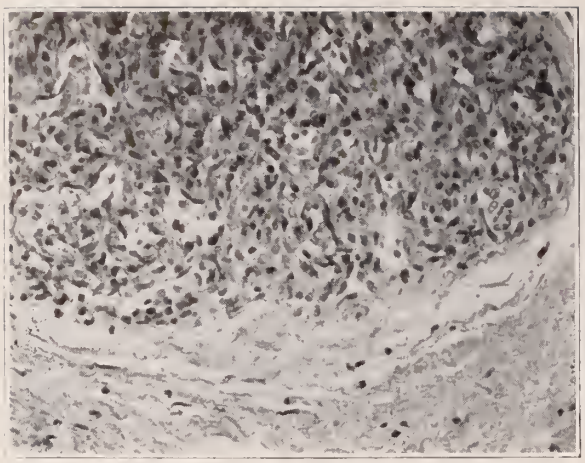

Fig. 2—Solid, moderately anaplastic lymphangiosarcoma in subcutaneous tissue (H & E, X 340).

in diameter. These lesions did not extend distal to the elbow. They were located in the epidermis but extended also into the corium, the subcutaneous tissue, and striated muscle. Much axillary scarring was present. There was a pathologic fracture of the humerus 8 cm. distal to the head of the bone; but this site was not involved by tumor, and presumably the fracture had occurred as a complication of disuse or x-ray osteoporosis and as a physical effect of the weight of the huge extremity. Elsewhere in the bones of the extremity no evidence of tumor was found. Sections of the skin through the lesions revealed fibrinous edema of the epidermis and dermis and an increase of collagenous fibrous tissue, although there were actually few fibroblasts to be seen. Foci of proliferating lymphatics could be seen in the dermis and especially in the subcutaneous tissue and muscle. Such channels of neoplastic tissue were free of blood, although recent hemorrhage had occurred into some. Nearby blood vessels were engorged, and the proliferation of lymphatic vessels was frequently perivascular. For the most part the endothelial cells lining such lymphangioblastic spaces appeared quite innocuous. One did find foci, however, in which these cells were enlarged and contained hyperchromatic, enlarged nuclei and mitotic figures (Fig. 2); and such cells projected into the lumen of the lymphatic channels. We concluded that these were invasive, anaplastic endothelial cells. This tumor differed completley from the breast cancer originally resected and of which we found no evidence in the arm. We had, then, a second malignant tumor, a lymphangiosarcoma, occurring seven years after mastectomy.

This specific entity, lymphangiosarcoma occurring in a postmastectomy lymphedematous arm, was first described in 1948 by Stewart and Treves,[1] as Doctor Britt revealed. In their article they cited 6 cases. Since that time 11 additional cases have been described in the literature. With the present case, a total of 18 cases is available for comparison. I have no doubt that over the many years since mastectomies were first done many additional patients developed lymphangiosarcoma in their postmastectomy lymphedematous extremity. These lesions were evidently mistaken for Kaposi's multiple idiopathic hemorrhagic sarcoma, metastasis of a recurrent breast carcinoma, or another type of angiosarcoma. We have summarized (Table 1) the significant data in the 18 known cases of postmastectomy lymphangiosarcoma. They are the cases of Stewart and Treves;[1] Vos;[2] Jessner and associates;[3] Rawson and Frank;[4] Hilfinger and Eberle;[5] Ferraro;[6] Southwick and Slaughter;[7] McCarthy and Pack;[8] Froio and Kirkland;[9] Cruse, Fisher and Usher;[10] and our own single case.

The effect of treatment given is of some interest. In 5 instances the results were not stated. In 9 cases metastasis of the lymphangiosarcoma to the chest and the lungs occurred in spite of treatment, 7 of these patients having been treated by amputation and 2 by irradiation. In 4 other patients the lymphangiosarcoma either cleared up or, at any rate, did not metastasize following treatment, such treatment having consisted of x-ray in 2 instances and amputation in the other 2.

Dr. P. W. Phillips: What is the follow-up in this case?

Doctor Dietz: The patient survived nine months following amputation of the arm. Before she expired an additional series of x-ray treatments was given to the right shoulder and the right thorax because of spread of the lymphangiosarcoma to the chest wall and the site of amputation. It is most unfortunate that of the 18 cases of which we are aware only 4 were examined by autopsy. This patient likewise was not available for necropsy, and therefore we do not know

TABLE 1—*Summary of Cases of Lymphangiosarcoma in Postmastectomy Lymphedema*

Neoplasm of Breast	
Right, malignant	5
Left, malignant	11
Right, benign	1
Unstated	1
Age of Patient at Mastectomy	
37–40 years	2
41–45 years	4
46–50 years	4
51–55 years	2
56–60 years	6
Metastasis of Cancer to Axillary Nodes	
Present	3
Absent at mastectomy	8
Unstated	7
Postmastectomy Infection of Operative Site	
Present	1
Absent	5
Unstated	12
Onset of Postmastectomy Lymphedema	
Immediately postoperative	10
One to several weeks after mastectomy	3
1–5 years after mastectomy	3
10 years after mastectomy	1
Unstated	1
X-ray Therapy for Breast Lesion	
Given postoperatively	6
Given preoperatively	4
None administered	2
Unstated	6
Interval Between Mastectomy and Lymphangiosarcoma	
6–8 years	6
9–11 years	6
12–16 years	4
24 years	1
Unstated	1
Treatment Given for Lymphangiosarcoma	
X-ray therapy only	5
Amputation of arm	9
No treatment given	1
Unstated	3
Results of Treatment of Lymphangiosarcoma	
Metastasis after irradiation	2
Metastasis after amputation	7
Improved after irradiation	2
Improved after amputation	2
Unstated	5

whether metastasis to deep-seated viscera had occurred. In only one of the cases does the record cite spread more distant than the thorax; in that case there was metastasis to the tonsil.

Dr. E. E. Gallagher: This lymphangiosarcomatous development is something new, to be sure, but we have always had elephantiasis postoperative to amputation of the breast. I have often wondered what causes this lymphedema to develop. Is it due to traumatic axillary surgery, to x-ray therapy, or infectious processes? All these may be the cause, but no one seems to have a definite answer.

Doctor Britt: If one considers the possible causes of postmastectomy lymphedema of the arm, it becomes apparent that the obese patient experiences a higher incidence, particularly of severe lymphedema because there is more surgical fat necrosis with consequent scarring in the axilla. Another cause of lymphedema often mentioned is infection in the operative site. What disturbs me a bit when consulting the literature on this subject is that authors apparently list only fulminating infections of the mastectomy site. In many patients there is a little necrosis along the edges of the skin flap, and this in itself is an avenue for infection. Very often, if one looks carefully, he can note a low-grade inflammation of the flap before it is completely healed. Once slight edema has started, that patient is a good candidate for lymphangitis of the arm and may have repeated flareups of mild acute cellulitis and lymphangitis. I think almost everyone believes that basically the postoperative lymphedema is the result of scarring of the remaining lymphatics in the axilla. MacDonald[11] states that resection of the axillary vein with the *en bloc* dissection of the axilla decreases the frequency and degree of edema. Prophylactic penicillin has had no effect on the incidence,[12] and cortisone has been used without success.[13]

Dr. R. L. Gilbert: What actually is the incidence of postoperative lymphedema of the arm in people undergoing mastectomy?

Doctor Gallagher: It is under 5%.

Doctor Dietz: It is my impression that the incidence is greater.

Doctor Britt: I think you are referring to all cases, even those where there is a slight degree of lymphedema.

Doctor Dietz: You are talking about "elephantiasis chirurgica." Stewart and Treves state that at Memorial Hospital, New York, 70% of patients undergoing mastectomy develop some degree of lymphedema of the arm following the operation.[1] Lobb and Harkins noted it in 80% of patients,[14] Holman and associates in 70%,[15] and Daland in 55%.[16] I believe it is as Doctor Gallagher said that approximately 5% develop severe, troublesome edema. A larger number will develop moderate lymphedema of the arm.

(Continued on page 614)

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negligible side effects

(Continued from page 611)

Doctor DuBois: How do you treat post-mastectomy lymphedema once it arises, other than suspending the arm overhead at night?

Doctor Gallagher: There have been some operations devised employing plastic tubes which drain beneath the skin into the axilla, but I don't believe they have been entirely satisfactory.

Doctor Britt: It is more profitable to try to prevent this condition than it is to treat it once it occurs. Early mobilization of the arm after the operation, avoidance of surgical infection and damage to the axillary vein, and placement of the incision so as to avoid the axilla and arm are basic to that concept.[17, 18] You mentioned suspension of the arm at night. I think it is a good suggestion in the treatment of established lymphedema of the arm, and I have used that method. Have the patient put a tight glove on the hand with some attached cords leading to a rope and pulley and counter-traction and keep the arm so elevated overnight. During the daytime she can wear an elastic bandage. This, of course, is most successful in the less severe cases. For the case with elephantiasis there is not much one can do. Plastic tube insertion and the Kondoleon operation as done in filariasis have not produced hoped-for results.

Doctor Dietz: An interesting question comes to mind; namely, what role in the pathogenesis of this lymphangiosarcoma did lymphedema play? Doctor Britt mentioned filariasis a moment ago. Such lymphangiosarcomatous complications are not reported as occurring in filariasis, and therefore one should not blame the lymphedema exclusively.

Dr. L. G. Joseph (Intern): I have a question along a similar vein. Aside from considerations of lymphedema, axillary metastasis, x-ray therapy, or infection as possible etiological factors in the development of this secondary tumor, is it more than coincidence when a patient who has a malignant tumor develops another tumor of malignant nature entirely different from the first?

Doctor Dietz: I take it you mean, when a patient develops a second malignancy, is that due to chance or is it on some insidious basis. The incidence of multiple malignant tumors in a patient with one malignant tumor, treated or untreated, is six times greater than would be expected on the basis of chance alone. The incidence of multiple primary malignant neoplasms in patients with an established malignant tumor is stated to lie between 1.7% and 8.2%, the average incidence being 3 to 4%. We know that multiple tumors will most often occur in the same organ; next most often in organs of the same type, that is in paired organs; next most often in the same organ system; and least often in entirely divergent portions of the body. Thomas, Dockerty, and Waugh[19] found that 3% of patients with a single cancer of the large intestine had more than one primary cancer of the colon. They collected a total of 132 cases of multiple colonic malignant neoplasms occurring during a 37-year period at the Mayo Clinic. We know that multiple cancers are not rare and that they are not due to chance occurrence alone. Such multiplicity is apparently not entirely related to senescence. The cancer factor in the family history is present more often in patients with multiple cancers than it is in patients with one cancer. The conclusion can be drawn that a constitutional susceptibility to the development of malignant tumors exists in some humans.

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AMERICAN BOARD OF INTERNAL MEDICINE ANNOUNCES CHANGES IN REQUIREMENTS GOVERNING ADMISSION TO WRITTEN AND ORAL RE-EXAMINATIONS

I. Written Examination

(1) The interval between the first and second written examinations will be not less than one year.

(2) The interval between the second and third written examinations will be not less than two years.

(3) The interval between all written examinations that may be permitted after failure of a third written examination will be two years. Admission to any subsequent written examination after failure of the third one may be granted at the discretion of the Board.

(4) A fee of twenty-five dollars ($25.00) is required for each written re-examination. This fee is due upon application for re-examination.

II. Oral Examination

(1) The interval between the first and second oral examinations will be not less than one year.

(2) The interval between the second and third oral examinations will be not less than two years.

(3) A candidate who fails the oral examination for the third time will be required to pass the written examination again before further oral examinations are permitted. Having done this, he becomes subject to the same regulations and priorities in respect to the oral examination as apply to candidates who pass the written examination for the first time.

(4) A fee of fifty dollars ($50.00) is required for each oral re-examination. The fee is due upon application for re-examination.

(5) The effective date of the changes referred to governing readmission to written and oral examinations will be January 1, 1956.

Oral examinations scheduled by this Board for 1956 are as follows:

Oral Examination Center	Closing date for acceptance of applications
New Orleans February 7–10, 1956 For candidates in the South and Southwest	January 3, 1956
Los Angeles April 12–13–14, 1956 For candidates on West Coast	January 3, 1956
Chicago, Illinois June 7–8–9, 1956 For candidates in Midwest	January 3, 1956
New York City September 21–22–24–25, 1956 For candidates on East Coast	April 1, 1956
Written Examination, October 15, 1956	May 1, 1956

OFFICIAL CALL FOR

Scientific Exhibits

★

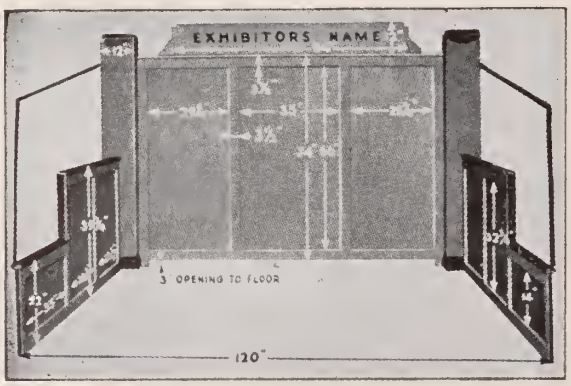
1956 ANNUAL MEETING **MILWAUKEE** **MAY 1–2–3**

★

THE Council on Scientific Work is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1956 Annual Meeting. The exhibits will be located in Bruce Hall of the Milwaukee Auditorium.

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space at the 1956 meeting are requested to file an application BEFORE FEBRUARY 1, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed.

In-state exhibitors will have the following facilities provided by the State Medical Society: Wooden booth, electrical connection, shelving or tables, and identifying sign.



The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, special lighting equipment, and half the cost of any drapes rented (rented through Badger Flag and Decorating Company at time exhibit is installed).

Booths for scientific exhibits are constructed of gray wood, in the dimensions shown on the chart at the left. Display space at back panel: 6′5″ high. Display space at sides: 6′5″ in height for 5′10″—remaining 3′2″ is 4′10″ in height.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit by February 1. *No applications can be accepted after that date.* Address your communications to Kenneth Lemmer, M.D., director of scientific exhibits, % The State Medical Society of Wisconsin, 330 East Lakeside St., Box 1109, Madison 1, Wis.

APPLICATION

For Participation in the Scientific Exhibit

1956 ANNUAL MEETING MILWAUKEE MAY 1-2-3

Fill Out and Mail to:

KENNETH LEMMER, M. D., *Director of Scientific Exhibits*
c/o State Medical Society of Wisconsin
330 East Lakeside Street
Box 1109
Madison 1, Wisconsin

1. Title of exhibit:_____

2. Description of exhibit (attach 200-word description to this blank):_____

3. The standard booth is 10′ wide and 9′ deep. What is the *minimum* space your display will require?_____
(Space is scarce so do not request more than is necessary).

4. Will radiologic viewing boxes be used? If so, will you furnish them?_____
(The State Medical Society does not have equipment of this character available).

5. Name of exhibitor:_____

6. Name of institution cooperating in exhibit: _____

COURSE IN ELECTROCARDIOGRAPHIC INTERPRETATION

A course in electrocardiographic interpretation for *graduate physicians* will be given at the Michael Reese Hospital, Chicago, by Louis N. Katz, M. D., (Director of the Cardiovascular Department, Medical Research Institute) and associates, each Wednesday from 7 to 9 p.m. for twelve weeks, beginning February 8.

Further information and a copy of the lecture schedule may be obtained upon application to Mrs. Ana Rose, Administrative Secretary, Cardiovascular Department, Medical Research Institute, Michael Reese Hospital, Chicago 16, Illinois.

. . . . THE PRESIDENT'S PAGE . . . .

RECENTLY a proposed advertising code was drafted by the Advertising Code Subcommittee of the National Association of Insurance Commissioners. This code has a direct bearing on the advertising policies of all commercial insurance plans and also Blue Shield and Blue Cross.

Several of the rules set forth governing the advertising of accident and sickness insurance have broad significance for our plans here in Wisconsin. While it is realized that the insurance laws of the state prohibit the transmission of information in the form of advertisements which may deceive, and the insurance commissioners tend to strengthen these laws, it is well to consider that regulations which may be unduly restraining could have a harmful effect on proper "merchandising."

In the section of the code under advertising of benefits payable or losses covered, it is pointed out that words or phrases shall not be used in "a manner which misleads or has the capacity and tendency to deceive prospective policyholders. . ."

The explanation goes on to point out that the words and phrases "all," "full," "complete," "comprehensive," "unlimited," "up to," and others with similar connotations shall not be used so as to exaggerate any benefit beyond the terms of the policy, but may be used in such "manner as fairly to describe such benefit."

Many of us are familiar with the methods employed by merchants to sell their merchandise, and it is generally agreed that a certain amount of "inflating of wares" is to be expected and could be construed as "good merchandising."

Unwise indeed would be the merchant who would advertise the shortcomings of his product so as not to antagonize the customer. True, his claims should be sufficiently sincere in order that he might "properly deliver the goods" to his customers; but at the same time, in order to stay in business and be successful, he must promote his product.

The restrictions which the N.A.I.C. recommendations could impose on the advertising of sickness and accident insurance might well be detrimental to the proper merchandising of these types of insurance.

My remarks are not to be interpreted to mean that I am not for proper surveillance in this field. On the contrary, I believe we need and must have continued strong controls in order to protect persons buying health insurance. But it is a good idea to keep in mind that, while certain restrictions imposed on the advertisements are intended for the protection of the consumer, they might be "handcuffing" the persons responsible for proper enrollment or "merchandising."

If the advertising does not inhibit the truth, is factual, and does not overemphasize points which may tend to mislead, then it should be considered ethical. Inhibiting regulations, we must realize, sometimes retard progress—progress which is essential in health insurance as well as free enterprise and all it symbolizes.

Irvin L. Bernhart M.D.

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". . . our studies indicate that ulcer pain in the uncomplicated case is invariably associated with abnormal motility. . . .

"Prompt relief of ulcer pain by ganglionic blocking agents . . . coincided exactly with cessation of abnormal motility and relaxation of the stomach."

Pro-Banthine Bromide (β-diisopropylaminoethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) is a new, improved, well tolerated anticholinergic agent which consistently reduces hypermotility of the stomach and intestinal tract. In peptic ulcer therapy[2] Pro-Banthine has brought about dramatic remissions, based on roentgenologic evidence. Concurrently there is a reduction of pain, or in many instances, the pain and discomfort disappear early in the program of therapy.

One of the typical cases cited by the authors[2] is that of a male patient who refused surgery despite the presence of a huge crater in the duodenal bulb.

"This ulcer crater was unusually large, yet on 30 mg. doses of Pro-Banthine [q.i.d.] his symptoms were relieved in 48 hours and a most dramatic diminution in the size of the crater was evident within 12 days."

Pro-Banthine is proving equally effective in the relief of hypermotility of the large and small bowel, certain forms of pylorospasm, pancreatitis and ureteral and bladder spasm. G. D. Searle & Co., Research in the Service of Medicine.

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The threat came from a red-headed woman dressed in corset and bloomers, with a Colt .45 lashed to her waist. And as the crowded lifeboat marked *S.S. Titanic* lurched into the waves, she rowed too, rowed until her hands bled.

Mrs. Margaret Tobin Brown had come a long way to take charge of that lifeboat. Once penniless, she now had millions, for her husband, "Leadville Johnny" Brown, had struck it rich. Once spurned by Denver society, she now hobnobbed with nobility.

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A.M.A. Praises Blue Shield Participating Physicians

Professionally sponsored nonprofit health insurance was "commended to the American public as a means of financing medical care" when the House of Delegates of the American Medical Association took action on several resolutions dealing with Blue Shield during its session in Boston, November 29–December 1.

In addition, the A.M.A. commended physicians who participate and cooperate with medical society-sponsored plans "for the important services being rendered in health care for the American people."

Dr. W. T. Casper, Milwaukee, attended the A.M.A. session and meetings of the National Blue Shield Commission as a representative of the Wisconsin State Medical Society's Commission on Prepaid Plans, which operates Wisconsin Physicians Service.

Because of the significance of the A.M.A. statement, it is reproduced in full:

> "WHEREAS, The participating and cooperating physicians of medical care plans sponsored by county, state and local medical societies are making a valuable contribution in the public interest by furthering the development of voluntary prepaid medical care for the people of America; and
>
> WHEREAS, More than 100,000 members of the American Medical Association are participating and cooperating in physician-sponsored prepaid medical care plans; therefore be it
>
> *Resolved,* That this House of Delegates commend these physicians and the medical society-sponsored plan in which they participate and cooperate for the important services being rendered in health care for the American people; and be it further
>
> *Resolved,* That the American Medical Association reaffirm its approval of medical society-sponsored nonprofit prepaid medical care plans as a means for financing medical care."

In approving another resolution commending professionally sponsored plans, the A.M.A. House of Delegates approved "the actions and accomplishments of the Blue Shield Association of Medical Care Plans." This is the national organization of Blue Shield plans.

The latter resolution recounted the action of the A.M.A. as early as 1945, ordering the A.M.A. Board of Trustees to "proceed with investigation and formation of a national organization to provide and serve the American people with prepayment health protection." Out of this action, in part, the national Blue Shield organization was formed in 1946. It included nine local Blue Shield plans covering about two million people. Now the organization includes 77 plans offering surgical-medical protection to 33 million persons.

Concerning still another resolution dealing with professionally sponsored plans, the House of Delegates said there is a "distinct need for a greater degree of uniformity and for some minimum standard provisions among medical society-sponsored voluntary prepaid insurance plans. . . This is appropriately a task to be performed by the plans themselves, and particularly by the Blue Shield Commission, and it is not properly in the province of the American Medical Association."

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THE WISCONSIN MEDICAL JOURNAL

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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Volume 54 DECEMBER 1955 Number 12

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Business Bureau Boosts Better Health

"There are many occasions when hasty action, without specialized knowledge, may have unexpected and serious consequences. The layman who enters into an involved contract without the counsel of a lawyer, the uninformed investor who does not seek competent financial advice, the person without mechanical training who tries to repair his car—all may have serious difficulties or losses which expert advice or assistance would have prevented.

"So it is with self-medication. To the uninitiated, the law, corporate finance, or the mechanics of a motor car are complicated and often mysterious subjects; but the human body is the most complicated 'machine' ever created. Not all of its processes are completely understood by those who devote their lives to a study of them. It is not surprising, therefore, that persons without medical training who attempt to diagnose and treat their serious ills often do themselves irreparable harm."

These words introduced an unusually effective and informative booklet being distributed by the Better Business Bureau of Milwaukee. Entitled "Facts You Should Know About Health Cures," the booklet cautions against trying to diagnose and treat your own serious or chronic ailments. At the same time, it identifies many of the objectionable products used in self-medication and exposes a variety of so-called drugs, devices, cosmetics, and appliances which are proposed for the treatment of all kinds of conditions from alcoholism to wrinkles. Pointing out that there are many products useful as first-aid treatments and others of value in relieving symptoms of minor acute ailments and superficial lesions, the booklet repeatedly emphasizes that, if the illness persists or relief is not obtained in a reasonable time, a physician should be consulted.

Weird diagnostic and therapeutic tricks and devices are as old as the hills, but there is a new application every day. The cures for arthritis, cancer, and rheumatism enjoy continuous popularity and give tragically disappointing results. Current advertisements for bust developers do nothing but deflate the pocketbook. The rash of baldness cures serves only to gray the hair of physicians who still have any. Probably no devices are so widely used and, for the money expended, so ineffective as those which purport to grow eyelashes, rejuvenate the skin, remove wrinkles, increase height, remove superfluous hair, remove moles, take off or put on fat, and increase or decrease sexual proclivity.

Too often we are inclined to think of such remedies and devices as flourishing only in the days of the horse and buggy doctor. Unfortunately, they are increasing rather than declining.

The State Medical Society commends the Better Business Bureaus for fighting fraud wherever they find it and helping the public obtain confidence and satisfaction from its relations with business of every kind.

"THERE'S ALWAYS A

Leader . . . . . MALLARD, INC."

Our aim is to help you, Doctor . . .

People turn to you when illness strikes. The latest drugs are only as good as your careful diagnoses. Recognizing your great responsibility, we accept our duty of providing you with the finest pharmaceuticals. Each one is exactly as labeled, carefully controlled in manufacture, carefully tested and analyzed. You'll find ours a complete line to save you time searching. You'll find our service fast—each order is shipped the same day it is received. Helping you to care for your patients is our single goal. Thank you for your confidence.

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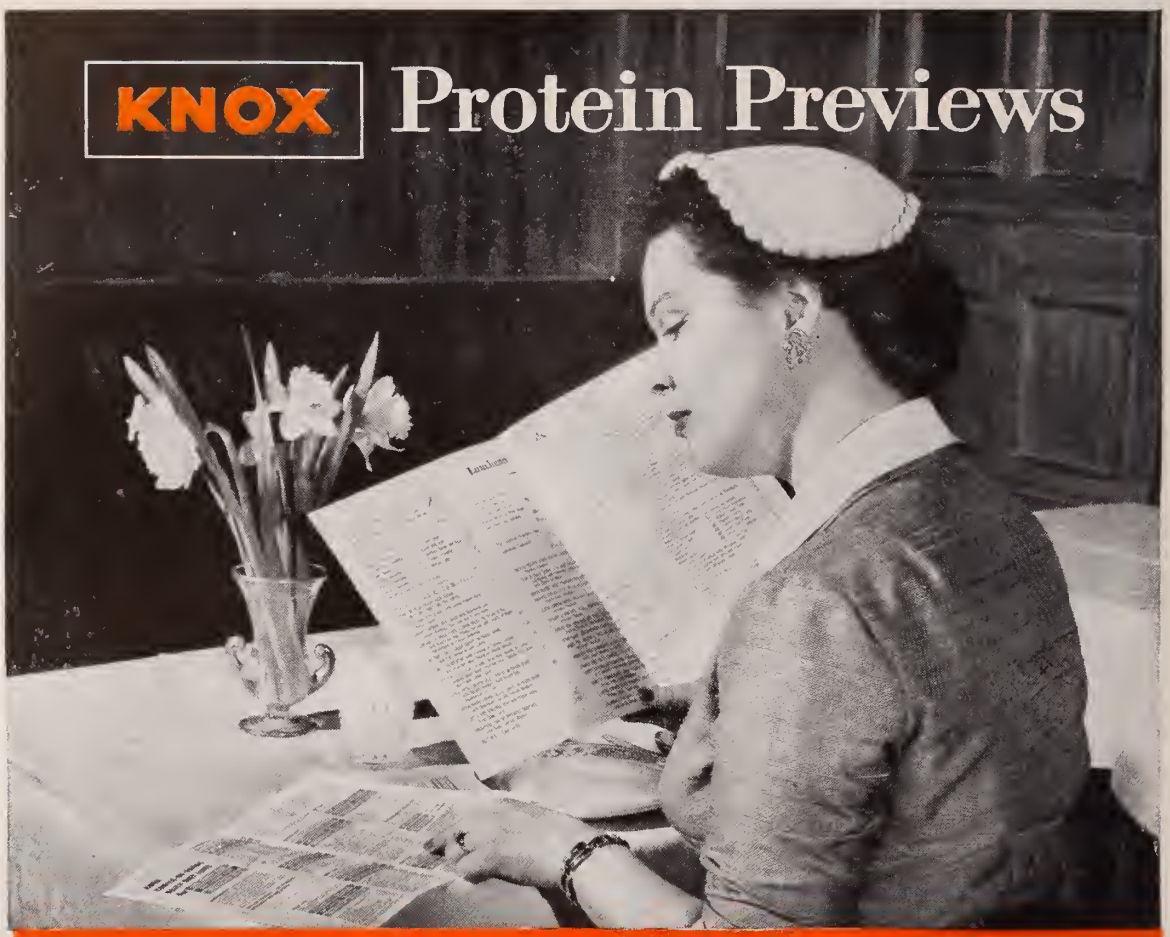

New Knox Food Exchange Chart Eliminates Calorie Counting

To help your obese patients reduce and stay reduced, Knox introduced this year a new dieting plan based on the use of nutritionally tested Food Exchanges.[1] The very heart of this new dietary is a "choice-of-foods diet list" chart which presents diets of 1200, 1600 and 1800 calories.

Each of these diets may be easily modified to meet special needs. However, the important points for your patients are that the use of this chart eliminates calorie counting, permits the patient a wide range of food choices and dispels that old empty feeling by allowing between-meal snacks.

These advantages should make your management of difficult and average cases easier. If you would like a supply of the new Knox charts for your practice, just fill in the coupon below.

1. Developed by the U. S. Public Health Service assisted by committees of The American Diabetes Association, Inc. and The American Dietetic Association.

Chas. B. Knox Gelatine Co., Inc.
Professional Service Dept. SJ-12
Johnstown, N. Y.

Please send me_____copies of the new, color-coded "choice-of-foods diet list" chart.

YOUR NAME AND ADDRESS:

Minutes of the Council Meeting, Milwaukee May 1, 1955

1. Call to Order

The Council was called to order by Chairman Arveson at 2:25 p.m., Sunday , May 1, at Milwaukee.

2. Roll Call

Councilors present were Doctors James, Lokvam, Hill, Kasten, Dessloch, Heidner, McCarey, Fox, Bell, Garrison, Arveson, Ekblad, Galasinski, Bernhart, Casper, Wegmann, and Past-President Tenney.

Others present were Speaker Simenstad; Vice-Speaker Fons; Drs. S. E. Gavin, W. D. Stovall, J. C. Griffith, and D. H. Witte, delegates to the American Medical Association; Dr. J. P. Conway, member of the Committee on Public Policy; and Dr. S. A. Morton, chairman of the Reference Committee on Reports of Officers. Guests present were Dr. C. N. Neupert, state health officer; Dr. C. L. Oppegaard, chairman of the Council, Minnesota State Medical Association; and Dr. J. Arnold Bargen, Mayo Clinic, Rochester, Minnesota.

Staff members present were C. H. Crownhart, secretary; R. T. Ragatz, assistant secretary; T. J. Doran, claims director; Robert B. Murphy, legal counsel; W. C. White, Jr., actuarial consultant; and Misses Joan Pyre and Jean McGruer.

3. Approval of Minutes Laid Over

The Council was advised that minutes of the February meeting were to be published in the May, 1955, *Wisconsin Medical Journal*, which was not yet available for distribution.

> On motion of Doctors Galasinski–Ekblad, carried, approval of such minutes was laid over to a subsequent meeting.

4. Introduction of Guest

Chairman Arveson introduced Dr. C. L. Oppegaard, of Crookston, Minnesota, who is chairman of the Council of the Minnesota State Medical Association.

5. New Business Request

Dr. W. T. Casper, Milwaukee, requested a discussion of a group malpractice insurance contract, and the item was added to the foot of the agenda for later action.

6. Interprofessional Code

The Interprofessional Code, developed by the State Medical Society of Wisconsin and the Wisconsin Bar Association, was submitted to the House of Delegates in October, 1954. Recognizing that final refinements might be necessary, the House approved the Code in principle, and authorized the Council and the Grievance Committee to make such further changes as appeared necessary.

Final revisions, which had been accepted by the Wisconsin Bar Association and the Grievance Committee of the Society, were presented to the Council for its action, with the recommendation that the Code be issued as a joint publication with the Wisconsin Bar Association to be distributed to all practicing attorneys and physicians, with provision for its distribution in the future to the students in the junior and senior classes of the Marquette and University of Wisconsin schools of medicine and law and provision for its distribution to new members of the State Medical Society.

> On motion of Doctors Ekblad–Casper, carried, the Council approved the Interprofessional Code as revised and authorized the staff to proceed with the project as outlined.

7. Report of the Committee on Public Policy

Dr. James P. Conway, Milwaukee, a member of the committee, presented its report to the Council. (The report is printed in its entirety, as part of the transactions of the House of Delegates, page 490, September, 1955, issue of *The Wisconsin Medical Journal.*)

The report was presented for the information of councilors and officers, and no action was required.

8. Section on Medical History

Dr. W. D. Stovall, Madison, chairman of the Section on Medical History, reminded the councilors and officers of the annual meeting of the section and urged their attendance. He said, "I think this Section on Medical History is a great thing for the Medical Society. Not only does it keep us all reminded of what has gone before us, the men who preceded us and what they did, but it is a very fine means of public relations because everyone is interested in history. It also integrates and correlates the progress of medicine with other activities."

9. Committee on Industrial Health

A brochure entitled "Guiding Principles of Occupational Medicine" was recommended for approval by the Committee on Industrial Health, a standing committee of the Council on Medical Service. It was pointed out that the brochure was developed by the Council on Industrial Health of the American Medical Association, which requested such endorsement. If approved, the principles would be included in a pending revision of the "Guide for Medical and Nursing Personnel," published jointly by the State Medical Society and the State Board of Health.

After discussion, and on motion of Doctors Hill–Kasten, carried, the Council approved the guide, and the recommendation that it be referred to the House for its action.

10. Review of Files of Deceased Physicians

A staff recommendation was to review the files of deceased physicians ten years after death of the physicians. Files would be checked carefully to eliminate anything of a confidential or personal character, then reviewed with the Section on Medical History to determine material of historical interest. Periodically, such files as were cleared would be turned over to the State Historical Society, which has mechanisms for preservation of their contents. It was contemplated that this be a continuing project worked out jointly by the Section on Medical History and the Historical Society, under supervision of the secretary.

Doctor Arveson urged Council approval, and on motion of Doctors Ekblad–Galasinski, carried, the Council acted to approve the project.

11. Physician Members, Blue Cross Corporation

In accordance with section 180.32 of the Statutes of Wisconsin, under which Associated Hospital Service, Inc., operates, the physicians and surgeons who are appointed to membership in that organization are subject to the approval of the State Medical Society of Wisconsin. The following physician members have been appointed since the last approval was given:

E. J. Nordby, Madison
Bernard Kulkoski, Green Bay

On motion of Doctors Hill–Heidner, carried, the Council confirmed the appointment of these physicians to the Blue Cross corporation.

12. Report of the Treasurer

The report was presented by the secretary on behalf of Dr. F. L. Weston, who was not able to attend the meeting. (The report itself was included in the transactions of the House of Delegates, page 477, September, 1955, issue of *The Wisconsin Medical Journal.*)

The Council approved the treasurer's report, for transmission to the House of Delegates, on motion of Doctors Ekblad–Hill, carried.

13. Scientific Studies

Various staff members reported with reference to scientific procedures in connection with studies to be reported in *The Wisconsin Medical Journal,* and upon motion duly made, seconded, and passed, the Council approved the mechanisms proposed.

On further motion of Doctors Galasinski–Kasten, carried, the Council expressed its appreciation to the various groups for the work being done.

14. Veterans Medical Service Agency

A problem which had arisen in the Veterans Medical Service Agency with respect to maximum billing of physicians was brought to the attention of the Council. It was reported that the Operating Committee of the VMSA would hold a special meeting on this subject prior to the July, 1955, contract date; and therefore, on motion of Doctors Dessloch–Galasinski, carried, the Council acted to defer action on the matter until a report was received from the committee.

15. Council Appointments

a. Interim Committee

The term of Dr. H. Kent Tenney, Madison, as a member of the Interim Committee having expired, the secretary, on nomination of Doctors Ekblad–Kasten, unanimously carried, was instructed to close the ballot and cast a unanimous vote for Dr. Arthur J. McCarey, Green Bay, as Doctor Tenney's successor.

b. Commission on State Departments

On motion of Doctors Dessloch–Ekblad, the following members of the Commission on State Departments were re-elected by unanimous vote:

H. A. Anderson, M. D., *Division on Tuberculosis and Chest Diseases*
R. F. Purtell, M. D., *Division on Maternal and Child Welfare*
Maxine Bennett, M. D., *Division on Visual and Hearing Defects*
H. A. Sincock, M. D., *Division on Crippled Children*
E. H. Pawsat, M. D., *Division on School Health*
Ray Piaskoski, M. D., *Division on Rehabilitation*
A. M. Hutter, M. D., *Division on Geriatrics*
H. W. Carey, M. D., *Division on Public Assistance*
E. D. Schwade, M. D., *Division on Nervous and Mental Diseases*

On motion of Doctors McCarey–Heidner, unanimously carried, Dr. T. W. Tormey, Jr., Madison, was re-elected chairman of the Commission on State Departments.

There was general discussion of the Commission on State Departments and its activities and projects, and of a staff recommendation to invite the Commission to join with the Council at its annual meeting in February, 1956. On motion of Doctors Ekblad-Casper, carried, the Council directed the secretary to invite the entire Commission on State Departments to meet with it in February.

16. Special Report of the Commission on Prepaid Plans

The Commission on Prepaid Plans, as a committee of the Council, reported the difficult problems being presented by various negotiations on the so-called "national" level.

Management and unions, in their bargaining conferences, are increasingly specifying types and extent of coverage, which in some cases are less and

in others are more, than WPS benefits, and in some situations extend coverage into areas of benefits not now written by WPS. An additional problem is presented by those negotiations seeking varying income levels for full payment.

The Commission asked authorization to enter experimentally into a program providing full payment of usual, reasonable, and customary charges of the physicians in the community, with some indemnity benefits acting as "controls" on utilization of the plan.

The Commission asked that its authority be flexible and, while outlining some of the tentative proposals in the field, suggested that the ultimate goal in the solution of the overall problem may be to disregard income levels entirely, although it might be more prudent to establish a limited schedule of benefits of five or ten items in order to assure actuarial soundness.

On motion of Doctors Dessloch–Hill, carried, following discussion, broad authority was given the Commission on Prepaid Plans to enter into programs along the lines suggested by it, with as much flexibility as seemed desirable.

At this point, 5:15 p.m., the Council recessed for dinner and reconvened at 8:00 p.m.

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17. Dr. Stephen Cahana

An Interim Committee recommendation was that, as provided under Section II, Article IV of the Constitution of the State Medical Society, Dr. Stephen Cahana, formerly of Milwaukee and now living in California, be granted an honorary membership in the Society. Doctor Cahana was born in Roumania in 1880, and was graduated from the University of Illinois medical school in 1911. Since that time, until his retirement in 1950, Doctor Cahana has been very active in the affairs of medicine, both as a practicing physician and as a teacher of clinical medicine. He is an ardent student and has given much of his time to civic activities. He has been a member in good standing of the State Medical Society for 40 years.

On motion of Doctors Dessloch–Heidner, the Council voted unanimously to grant an honorary membership to Doctor Cahana.

18. Assistant Treasurer

An Interim Committee recommendation was the addition of an assistant treasurer as an elected officer of the State Medical Society, with authorization to sign checks on the accounts to which the treasurer's signature is required. It was pointed out that the treasurer, Dr. Frank L. Weston, would be out of the country for the summer months and that signing blank checks in advance was not only impractical but an unacceptable accounting procedure.

The Interim Committee nominated Dr. H. Kent Tenney, Madison, to be assistant treasurer; and on motion of Doctors Dessloch–Garrison, unanimously carried, Doctor Tenney was elected and his signature authorized to those accounts to which it is required.

19. Social Security

Recommendations of the Council relative to this subject are reported in the proceedings of the House of Delegates, September, 1955, issue of *The Wisconsin Medical Journal*, pages 465, 466, and 493.

20. Student American Medical Association

By previous Council action the advisors to the Marquette University and University of Wisconsin chapters of the Student A.M.A. report annually on the status and activities of the chapters.

Reports on both chapters were made by Dr. J. S. Devitt, Milwaukee, advisor to the Marquette chapter, since Dr. C. G. Reznichek, Madison, was not able to be present.

Doctor Reznichek's report pointed out that the Wisconsin chapter appeared to be well organized, that its membership totaled 85 per cent of enrollment, and that 40 to 50 of its members participated in the national meeting of the organization. It was further reported that meetings were held at from one to three-week intervals, with excellent attendance. In conclusion, Doctor Reznichek's report stated that "the Wisconsin chapter of the S.A.M.A. is well organized and its activities are such that the State Medical Society can be proud to continue in its sponsorship and advisory capacity."

In reporting on the Marquette chapter of the S.A.M.A., Doctor Devitt said "it is continuing to fulfill early promises of developing into a healthy influence in American medicine." Membership of the Marquette chapter totals 295—75 per cent of total enrollment of the medical school. Doctor Devitt reported that the organization holds monthly meetings, has special projects and panel discussions, and takes an active part in the proceedings of the national group. He stated that a low-cost life insurance plan has been installed for the group. Doctor Devitt summarized the report by saying, "I feel the Council can be assured that the Marquette chapter is typical of the national organization, and is enjoying healthy growth and development. It is an asset to organized medicine and deserves our continued support and encouragement."

21. Dr. C. L. Oppegaard, Crookston, Minnesota

At the request of Chairman Arveson, Doctor Oppegaard, chairman of the Council of the Minnesota State Medical Association, addressed the Council briefly. He discussed generally the matter of liability insurance and the fact that it was currently under study in that association.

Doctor Oppegaard expressed his appreciation for being invited to attend the meeting and extended an invitation to the councilors and officers to participate in the annual meeting of the Minnesota Association later that month.

22. New Business—Liability Insurance

At this point Doctor Casper asked for discussion of his request made at the beginning of the meeting. After some discussion, he moved that the chair appoint a small committee to study the feasibility of negotiating a group liability insurance contract for the doctors of Wisconsin. The motion was seconded by Doctor Garrison and carried.

23. Dr. J. Arnold Bargen, Rochester, Minnesota

Doctor Arveson introduced a special guest, Dr. J. Arnold Bargen, professor of medicine at the Mayo Foundation and chief of the department of gastroenterology, Mayo Clinic, Rochester, Minnesota. Doctor Bargen was in Milwaukee in advance of his engagement to speak at the general scientific assembly in connection with the Annual Meeting.

24. Executive Committee of the Council

It was reported to the Council that its Interim Committee actually functioned within the powers generally assigned an executive committee. Without proper description, strangers to the organization of medicine were confused by the title "interim." On motion of Doctors Bernhart–McCarey and Fox, the Council voted to change the name to "Executive Committee."

25. Study of Structure of Executive Committee

On motion of Doctors Bernhart–Ekblad and Heidner, carried, the chair was authorized to appoint a committee to review the structure of the Executive Committee and the parliamentary implications of providing voting membership on the executive committee to those individuals not have voting privilege on the Council itself.

26. New Councilor, 13th District

Councilors and officers were saddened by the death of Dr. C. E. Zellmer, Antigo, as a result of an automobile accident in March. His term would have expired in 1956.

Dr. R. E. Garrison, Wisconsin Rapids, nominated Dr. William P. Curran of Antigo as successor to Doctor Zellmer. The nomination was seconded by Dr. Arthur J. McCarey, Green Bay. There being no further nominations, they were declared closed and the secretary instructed to cast the unanimous ballot of the Council for Doctor Curran.

27. Interim (Executive) Committee Report

a. Specialty Groups

The Interim Committee recommended that at a future meeting of the Council representatives of the several specialty groups and the Academy of General Practice be invited to meet with it with reference to those problems which are common to the entire practice of medicine, yet upon which there may be varying views.

On motion of Doctors Bell–Dessloch, carried, this recommendation was approved by the Council.

b. Marquette University

The Interim Committee recommended that the Council notify the House of Delegates that Marquette University this year celebrates its 75th anniversary, pointing out that the House would doubtless wish to recognize that occasion.

On motion of Doctors Ekblad–Kasten, carried, the Council approved this recommendation.

c. Date of Annual Meeting

The Interim Committee submitted for Council approval the recommendation that annually the president direct a notice to the two medical schools and various medical organizations, pointing out the date of the Society's Annual Meeting, and suggesting that to the extent possible there be no medical meeting which would have conflicting interest just prior to or within the week after our Annual Meeting.

The recommendation was approved by the Council on motion of Doctors Heidner–Garrison, carried.

d. Anti-Fluoridation Movements

The Interim Committee received a resolution from one of the county medical societies which requested investigation as to persons and influences behind the anti-fluoridation movements.

It was reported that the Interim Committee recommended that, unless there was objection from the Council, the matter be given further study and reported in detail at the July–August meeting of the Council. There being no objection, it was so ordered.

28. J. C. Fox, M. D.

Doctor Fox, Councilor from La Crosse, who is currently studying in Boston, said that he was happy to be able to be with the Council and extended official greetings of the Suffolk County Medical Society, Massachusetts.

29. Adjournment

There being no further business, the meeting of the Council adjourned at 10:00 p.m., Sunday, May 1, 1955.

C. H. Crownhart
Secretary

Approved:

R. G. Arveson, M. D.
Chairman of the Council

THE MEDICAL FORUM

PROPOSE NEW CATEGORIES OF MEDICAL CARE FACILITIES

WIAA SEEKS PHYSICIANS' HELP IN MAKING PREP FOOTBALL SAFER

Fond du Lac — The Wisconsin Interscholastic Athletic Association has asked Wisconsin physicians for recommendations to increase safety in high school football.

The request was made at a meeting here of the Commission on State Department's Subcommittee on WIAA of the Division on School Health.

Dr. Charles E. Koepp, of Marinette, WIAA medical advisor, said the organization would be receptive to suggestions to boost the physical welfare of athletes participating in prep football.

FAGAN SPEAKS

Clifford B. Fagan, Marinette, executive secretary of the prep governing organization, presented reports on two safety promotion programs being conducted by the WIAA.

These included:

Face Masks—**8,000 boys in 303 schools used the masks attached to football helmets as an experiment this past fall in protection of the face and particularly the nose and teeth. The WIAA allocated $15,000 in subsidizing this program, with the money derived from funds produced by basketball tournaments. A full report on the experimental project will be made later this winter by participating schools.**

Shoes—**On a trial basis, the Association tested canvas shoes with rubber soles. Mr. Fagan said a number of injuries had resulted in football play because of leather soles and plastic or metal cleats. A widespread program will be adopted in 1956 if the trial proves encouraging, he said.**

PROPOSAL RE HERNIAS

Upon motion by Drs. Donald W. McCormick, Fond du Lac, and Walton R. Manz, Eau Claire,

(Continued on page 30)

Mr. Fagan

Military Calls for Physicians Up in '56

Washington—The National Advisory Committee to Selective Service issued this warning this month:

"Between next July (1956) and June 30, 1957, military needs for physicians will be of such magnitude as to require active duty of all interns and residents who have not satisfied their military liability, and perhaps some liable physicians of priority III who are older and who may be established in practice.

"It will not be possible to support deferment for any current intern for residency training except those included in the Department of Defense's Residency Consideration Program and perhaps some in exceptional situations necessary to the national health, safety or interest."

The Committee did not elaborate nor did it explain why the residency requirements would be tightened.

State Plan Detailed At Public Hearing

Madison—Creation of four new separate categories of medical care facilities is provided in proposals relating to the Wisconsin Hospital Construction Plan, as advanced by the State Board of Health Nov. 29.

The new categories are chronic disease hospitals, diagnostic and treatment centers, nursing homes and rehabilitation facilities.

The Plan relates to the Hospital and Medical Facilities, Survey, Planning and Construction Act, enacted by Congress in 1946.

HOLD PUBLIC HEARING

More than 50 representatives of the medical profession, curative workshops, hospitals and other groups heard Vincent F. Otis, director of the Division of Hospital and Related Services for the Board, and Philip Dreifuss, Public Health Engineer in the same division, present summaries of the essential features of the State Plan. The presentations were made at a public hearing at Madison.

The proposed Plan, which will be submitted to the Surgeon General of the U. S. Public Health Service in the Department of Health, Education and Welfare for final approval, includes the methods of administration, statements of nondiscrimination and a description of the Plan's growth.

Since the Plan was developed in 1947, the State of Wisconsin has been allotted $16,000,000 in federal grants-in-aid to assist in construction of urgently needed hospital and health facilities. Specifically, 55 projects were approved and 2,500 hospital beds provided: 44 communities benefited, 37 of them rural.

IMPROVEMENTS ENCOURAGED

Otis said the over-all program had encouraged construction of

(Continued on page 30)

MEDICAL CARE . . .

(Continued from page 29)

new facilities and improvement of others. Many obsolete, non-fire resistive structures were replaced with modern physical plants. Overcrowding has been eliminated or reduced and diagnostic and treatment services expanded.

The State Plan is revised annually with the aid of a State Advisory Hospital Council, reporting to the State Board of Health.

By facility, the priority list and status of categories were announced as follows:

GENERAL HOSPITALS—**Top priority for aid was listed for Crandon, Adams, Park Falls, Stanley, Eagle River, Wautoma, Whitehall, Medford, Woodruff and Black River Falls. The number of service areas in the state was increased from 71 to 89. The Plan seeks ultimately to reach a goal of fewer but better located larger hospitals, resulting in more complete hospital service.**

TUBERCULOSIS HOSPITALS—No priority was developed because state has more beds available (1,910) than permitted by federal formula regulations (1,902). However, some areas have more than enough beds (i.e., Superior 158 for 87 patients), while others are short (i.e., Eau Claire and Wausau, each short 17). A study was recommended to determine long-range needs of specific areas for possible consolidation of some sanatoria.

ENABLING LEGISLATION

(The 1955 legislative session saw enactment of a bill permitting conversion of county TB sanatoriums into joint county homes for the aged or chronically ill.)

MENTAL HOSPITALS—**Number of beds available, 12,390; number allowed by state ratio, 17,870; beds needed 5,480. The Board said only 17 of 54 mental hospitals in Wisconsin meet federal definitions of these institutions. By regions the need for additional beds is as follows: Superior (329); Wausau (796); Eau Claire (508); Milwaukee (1,997); Oshkosh (424); Madison (451); La Crosse (111) and Green Bay (293).**

CHRONIC DISEASE HOSPITALS—Service areas (17) were proposed, following survey of needs. This done on geographic, rather than statewide basis. The Plan recognizes desirability of giving special consideration to chronic disease facilities. Total need of 7,148 beds reported, with the following cities listed for top priority: Wausau, Marshfield, Superior, Oshkosh, Fond du Lac, Manitowoc, Janesville, Racine and Kenosha.

LOCAL WISHES RECOGNIZED

PUBLIC HEALTH CENTERS—**Highest priority shall be given, under the Plan, to provision of facilities for local health units serving rural communities and those with small financial resources. The proposed centers will include such clinic facilities as desired by local communities. No additional priority pattern was devised to date.**

NURSING HOMES—A recent survey showed 2,548 persons obtaining nursing care and 1,247 in need of such care. Not included: 615 persons mentally infirm in mental hospitals in need of skilled nursing care, and 9,254 others needing lesser forms of personal services and supervision. On state ratio, 10,722 beds are permitted. The Plan showed 6,543 existing beds, and 4,179 more needed. Showing biggest need for facilities were: Spooner, Frederic–Grantsburg, Medford, Durand, Adams, Algoma, Tomah, Ladysmith, Woodruff, Darlington, St. Croix Falls, Amery, Richland Center, Mauston, Boscobel, Chilton, Waupun, Watertown, Columbus, Hartford, West Bend, Plymouth and Port Washington.

NEED MAJOR FACTOR

DIAGNOSTIC AND TREATMENT CENTERS—**Very little justification exists, Dreifuss said, for establishment of separate centers apart from hospitals, since such services are already being provided in smaller communities through offices of private physicians. First priority will be given for construction, remodeling and/or equipping of centers based on need. Pending further study, no priority pattern for individual areas was devised.**

REHABILITATION FACILITIES—These are being planned so that all persons eventually will have access to integrated rehabilitation services for all types of disabilities. Units proposed are not to exceed one for each 300,000 population. The ratio permits Wisconsin to have 12 centers, being programmed now on a statewide basis. The Plan outlined additional facilities for Madison, Milwaukee, Oshkosh, Green Bay, Eau Claire, Racine, La Crosse, Wausau and Lake Tomahawk.

Otis said he expected federal authorities to act on his proposals before Feb. 1.

WIAA . . .

(Continued from page 29)

the Subcommittee proposed that youngsters with hernias be banned from athletic competition by the WIAA. The action was sent to the Division of School Health of the Commission on State Departments for approval. If that is received, the matter must be cleared by the Commission for transmission to the WIAA Board.

(Currently the WIAA benefit plans do not provide indemnities for hernia.)

The Subcommittee urged that all schools be encouraged to conduct physical examinations for athletes as close to the school year as possible, and preferably in early fall.

SPRING TESTING

Mr. Fagan reported that only a few schools still were conducting examinations in late spring, as a holdover practice from World War II. As a result of WIAA prodding, he said, most schools are switching to fall examinations.

Dr. E. H. Pawsat, Fond du Lac, pointed out that the State Medical Society's school health examination booklet urged such physical testing be done close to the time the youth engages in sports.

REVIEW 1946 ACTION

Up for review was the Society's 1946 resolution which condemns interscholastic athletic competition below the senior high school level. Subcommitteemen said they were glad to learn the attitude of the WIAA coincided basically with that of the Society.

The matter will get further detailed study involving emotional and physical stress on young people, types of rivalry and supervision and equipment of junior high school sports teams.

Predict National Program of Disability Insurance and Medical Care in 10 Years

New York—Within the next 10 years, a national program of disability insurance and medical care may evolve, Isadore S. Falk, Stonington, Conn., told a regional meeting of the American Public Welfare Association.

Falk, a former director of research and statistics of the Social Security Administration, said:

"The public will not put up indefinitely with lack of adequate protection in these areas of major risk. Unwise leadership in the medical profession and in commercial insurance has made the goal difficult.

"Voluntary insurance schemes, serving some very useful roles, will continue to expand for awhile, but sooner or later, as their inherent inadequacies become increasingly evident, they will give way to public insurance of wages lost in short-term disabilities, and either to comprehensive public medical care insurance or to further growth of tax supported medical services.

"The inadequacies are inability to reach all the people who need it most—the needy, those who are not job-connected, and others."

After leaving the Social Security Administration, Falk was employed with the International Bank and was stationed for awhile in Malaya, where he made a study of health, education and welfare programs and needs in that country.

CONDUCT MEDICAL CARE "DRY-RUN" IN WASHINGTON

Washington—A "dry-run" on the U. S. Defense Department's legislative plan for broadening dependents' medical care privileges was conducted on a small Blue Cross–Blue Shield group in Washington this month.

It was reported as a smooth, skilled operation, a project that is nearing the final polishing-up stage for introduction early in 1956.

It was indicated that the Pentagon's plan apparently is to retain optional feature of prepaid insurance coverage but to continue emphasis upon care by military resources whenever and wherever possible.

A coffee hour opened a one-day seven-county Conference on School Health at La Crosse last month. More than 270 doctors, nurses, parents, teachers and school people attended the sessions at which Dr. Edgar S. Gordon (left), Madison, delivered the major address. Next to him is Dr. E. F. Rohde, Galesville. At right is John B. Coleman, La Crosse Vocational and Adult Schools director and assistant chairman of the regional planning committee for the meeting, who is speaking to Dr. E. H. Pawsat, Fond du Lac, chairman, Division on School Health for the State Medical Society. (La Crosse *Tribune* photo)

Revision of Medical Report Forms Underway

Washington—The medical advisory committee to the Social Security Administration recently devoted considerable time to revising report forms which are filled in by physicians examining applicants for "freeze" benefits.

Recommendations were made to alter the forms so as to have them present more specific diagnostic data, and to take necessary measures to promote understanding by doctors of what is desired.

It was reported the amended form would approximate that approved by the International Claim Association for use by insurance companies writing disability benefit coverage.

Your Family's Happiness and Future Depend on You!

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INSURANCE CO.
Milwaukee, Wisconsin

Old Story: Denver Chiropractor Loses Another Damage Lawsuit

Denver—For the second time this year, Leo Spears, the advertising Denver chiropractor, has lost a major lawsuit.

Spears brought an $11,000,000 suit against the Denver Area Better Business Bureau, the Denver *Post* and 80 other defendants whom he charged with conspiring to damage his chiropractic institution. One of the defendants was Harvey Sethman, executive secretary of the Colorado State Medical Society.

ILLEGAL OPERATION

Judge Robert H. McWilliams not only found that no conspiracy existed, but further ruled that the Spears' institution is being operated illegally. This, he said, was based on evidence that chiropractors are on salary there, even Spears himself.

Oliver Field, director of the AMA Bureau of Investigation, said the ruling, while it is appealable, may have significance in medico-legal circles in view of the current question of the practice of medicine by hospital corporations having radiologists and pathologists on their payroll.

This was the second setback for Spears in 1955. Tried in March was a libel action brought by the chiropractor against the Crowell-Collier Publishing Co., in New York federal court. Spears claimed $24,000,000 damages as a result of his being named in a Colliers' article entitled *Cancer Quacks*, published in May, 1951.

Of interest was the fact that attorneys for Colliers' were able to draw from Spears admissions that five of the six testimonial-givers in a cancer pamphlet called Good News were dead of cancer. The sixth was treated with escharotics for what may have been an epithelioma.

Other testimony revealed that neither Spears nor his "staff" was able to recognize a case of malignant disease in a youngster brought to his institution by her mother. She was asked to take the child elsewhere because "screams annoyed other patients." The child was being treated for rheumatism

Have you sent your contribution to the Society's Charitable, Educational and Scientific Foundation Inc.?

FEWER VETS SEEK MEDICAL GRANTS

Madison—Grants to Wisconsin military veterans for hospitalization and medical expenses declined during the fiscal period ending June 30, the State Department of Veterans' Affairs reported.

In the 12-month period, 118 applicants received $12,499 for hospitalization expenditures, and 85 received $5,905 for medical expenses. This compared with 280 applicants who were paid $31,642 for hospitalization, and 226 who received $19,679 for medical benefits in 1952.

Since the program was conceived by the 1943 legislature, hospital benefits (6,390 recipients) totaled $561,037, and medical payments (5,872 recipients) amounted to $409,513.

Department allotments, including those for rehabilitation, housing, education and all other purposes, aggregated $57,707,932 to 68,270 applicants in the past 12 years. This is a program of emergency assistance for World War II and Korean conflict veterans.

Farmwife Calls MD's "Real Friends"

Racine—Remember that letter to the editor in the *Wisconsin Agriculturist and Farmer* last month which assailed doctors for "taking every dime from patients"?

The letter followed a poll taken by the rural publication of reactions of farmers to fees charged by physicians and to services rendered.

The letter was signed by *"one who has paid through the nose, in Waupaca County."*

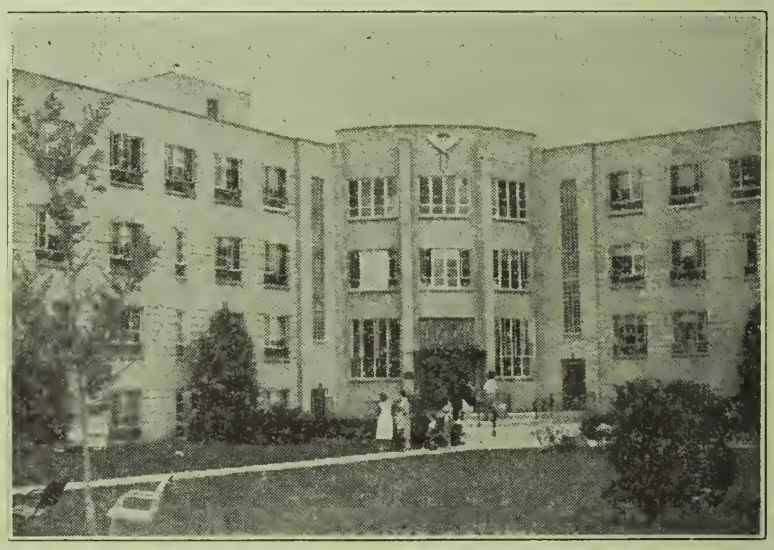
In answer, the following letter appeared this week:

"Here is my answer: Stop your grumbling about doctors' high fees, my friend, and thank God that we have the doctors. When you need a doctor's help, he won't ask if you'll be able to pay for it—your health comes first.

"I wonder why so many people are so thankless. A doctor's work is priceless. They save thousands of lives every year—still so many people don't appreciate them.

"Yes, doctors are our real friends"

The letter was signed by Mrs. Dorothy Furmanek, Portage County.



The Spears Chiropractic Sanatarium—Hospital in Denver consists of 800 beds. The entrance to the huge structure is shown above. Another unit, now under construction, will house 2,150 beds and be "dedicated to cancer research and treatment," according to a recent Spears' mailer. The new unit is claimed to be a 12 million dollar project. The chiropractor also has an out-patient facility. The Spears' Corporation was founded in 1934. It derives patients mainly by means of direct mail advertising and via newspaper advertising. Two publications, PROOF (48 pages) and MORE PROOF (24 pages) are sent out regularly. Emphasis is placed upon testimonial-type insertions in large numbers, with before and after pictures. Claims are made to relieving practically all ailments besetting man.

Predict Doctors Will Be Employed By Hospitals

Milwaukee—Higher professional standards were held out as the challenge of the nursing profession at the 45th annual convention of the Wisconsin State Nurses' Association at Milwaukee.

According to newspaper reports, Attorney Lee Loevinger, Minneapolis, counsel for the Minnesota Nurses' Association, told the group that, "if standards were raised in the nursing profession, the nurses would be better able to discharge their new functions." Loevinger said nurses were performing more functions which physicians formerly performed but that their incomes were not keeping pace with their increased responsibilities.

HIGHER SALARIES

Loevinger was reported as stating that raising the standards would limit the number of nurses coming into the profession, result in raising salaries, bring more able persons to the profession and ultimately increase nursing competence.

The Milwaukee Journal, reporting the conference, stated that Loevinger predicted that the professional nurse of the future would have a bachelor's degree and that there would be an intermediate group of nurses who would have about two and a half years' training. Then, he said, would come the licensed practical nurse and auxiliary personnel.

COSTS DISCUSSED

Higher salaries for professional nurses would not necessarily increase the cost of hospital care to a patient, provided the nurses were utilized more efficiently and economically, he stated.

He pointed out that nurses still had time consuming housekeeping duties such as making beds, bathing patients, carrying trays and keeping records of admissions.

"If we're going to have a hope of reducing the total cost, we'll have to find some method of combining the two types of charges," he was reported as saying. "Ultimately, a large part of the medical

(Continued on page 35)

"FAITH-HEALERS" RAPPED BY PRESBYTERIAN PASTOR

Richmond, Va., Nov. 21—So-called "faith healers" have manufactured a new cult, and their arrival "is a curse, a misery, a racket, a destruction of faith in simple people," an Atlanta, Ga., pastor said in *The Presbyterian Outlook* this month.

Carroll R. Stegall, Jr., of the Pryor Street Presbyterian church, wrote an extensive study of the problem in booklet form, and permitted excerpts to be printed in the church publication.

FAITH HEALERS

Referring mainly to faith healers who utilize the medium of television, Stegall stated:

"The modern Pentecostal claim that they have recovered the Apostolic gift of miraculous healing is a fraud. They have, instead, manufactered a new cult, using the age-old tricks of suggestion and psychological chant. So far from glorifying God with this, they cause his name to be blasphemed among the worldly by their excesses.

"So far from curing, they often kill.

SCREEN PROSPECTS

"People with mental and spiritual problems sometimes do get relief. People with no organic ailment are the ones the 'healer' hopes to get in his line. The others are left waiting, are promised help but don't receive it and are passed over for those who cause no great embarrassment. Prospects are carefully screened.

"Healers go to any length to procure testimonies. They will quote medical sources, true and false.

"These mountebanks place hedges all about their supposed power, and when they have deceived the congregation with their supposed healings, they plead weariness and beg to be excused. They depart, leaving the actual sick on the platform to come another night, endlessly.

SEEK GLORY, CASH

"What are these alleged healers after? They are seeking personal prestige and glory, and financial gain. A religious leader seldom is disgraced or abandoned. This is because his followers confuse faith in God with faith in the man they think is God. These men have been discredited time and again by events, but the people who follow them do not think—they feel."

Stegall says the freedom of religion "makes anything possible among us, and no law can touch such movements."

His solution, described as "very dubious" by editors of the *Outlook*, calls for a deeper emphasis upon . . . the fundamental doctrines of Christianity, over and against liberalism, ecumenicalism, social-gospelism and the like."

Old Medical Books Given to UW Library

Madison—A collection of old medical books, once the property of the late Dr. A. Schlapik, has been presented to the library of the University of Wisconsin Medical School.

The presentation was made by Dr. Urquhart L. Meeter, who is occupying the former offices of Dr. Schlapik in Kenosha.

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Dr. Neupert Active At National Meeting

Washington — A conference of state and territorial health officers with Dr. Leonard Scheele, Surgeon General of the U. S. Public Health Service, and Dr. Martha Eliot, Chief of the U. S. Children's Bureau, brought these recommendations:

1. That federal grant-in-aid funds for construction of hospitals be continued for an additional three years through extension of the Hill-Burton act until June 30, 1960. Bills authorizing extension will be introduced in Congress in 1956.

POLIO EXTENSION ASKED

2. That Congress assure fulfillment of its current polio vaccine program to provide sufficient Salk vaccine to states to immunize approximately one-third of all persons under 20 years. This involved extension of the cut-off date, Feb. 15, 1956 because, resolution authors said, manufacture is not proceeding fast enough to enable state to spend present allocations.

3. That state health departments designate a suitable administrative unit in their organization to appraise the needs for early detection of chronic diseases, for caring for the chronically ill and to be concerned with evaluation of all aspects of the total chronic disease problem.

DR. NEUPERT PARTICIPATES

Wisconsin's State Health Officer, Dr. Carl N. Neupert, served as vice chairman of the section dealing with state hospital surveys and construction, and on a committee of the Association of State and Territorial Health Officers. Dr. Neupert was president of the Association in 1953.

Marion B. Folsom, Secretary of Health, Education and Welfare, was an active participant in the conference.

Similar meetings are held each year in accordance with a federal law calling for the heads of two federal agencies to confer with state authorities on regulations relating to grants-in-aid to states. Also up for consideration were mental health, public health and civil defense matters.

Recommendations adopted by the Association are the result of final action in executive session.

Dr. Neupert

Pauly Fined Again For Illegal Practice In Milwaukee

Milwaukee—Louis C. Pauly of Milwaukee, a source of trouble for the State Board of Medical Examiners for more than 10 years, received another setback recently. He was fined $100 in district court here on a charge of treating the sick without a license.

Pauly, 82, was arrested last May on complaint of the board. He was charged with selling mineral salts to persons who complained of various ailments, including arthritis, heart disease and leukemia.

OLD STORY

In 1945, Dist. Judge Harvey L. Neelen placed Pauly on probation for two years on the same charge. At that time, Pauly admitted he was not a physician although he had described himself as a "homeopathic physician" in letters he distributed widely to possible clients.

Pauly told the court he was the son of a physician who had died in 1910, leaving a library of considerable scope. He said:

"I studied those books my father left me . . . real hard for three days, and I learned how to save my life and many others.

"It was those 12 body minerals that did it. They'll cure any ailment that exists."

MANY INQUIRIES

The State Medical Society files reveal many letters from Wisconsin residents, including teachers, attorneys and physicians, reporting Pauly's activities, asking clarification of his status and in many instances urging prosecution.

WISCONSIN DOCTORS ATTEND NO. CENTRAL MEETING IN ST. PAUL

St. Paul—A resolution voicing support of the Iowa State Medical Society's court fight against hospital control was adopted by delegates to the North Central Medical Conference Nov. 20.

The action followed a talk by Dr. Frank C. Coleman, Des Moines, who said the outcome of current litigation "would affect medical practice in all 48 states."

Dr. Donald H. Breit, of Sioux Falls, S. D., said:

HOSPITALS "COMPLICATED"

"Hospitals were originally designed only to provide facilities. Today they are big business, really complicated agencies. The wrong concepts concerning hospitals are being taught and promoted.

"Just what would be the status of an MD in a hospital which is taking over control of medical practice? This faulty status is gaining momentum, a situation which should be curtailed for the welfare of all."

Dr. E. L. Bernhart, Milwaukee, president of the State Medical Society of Wisconsin, participated in a discussion on "Lay-Sponsored Medical Plans." He explained Wisconsin policies, plans and progress.

ELECT DR. LARIMER

Dr. R. N. Larimer, Sioux City, Ia., was named president-elect of the conference. Dr. P. H. Woutat, Grand Forks, N. D., will become president in 1956.

R. R. Rosell, of St. Paul, host to the Conference for many years, was re-elected Secretary-Treasurer.

In addition to Dr. Bernhart, Wisconsin representatives to the meeting included Drs. R. G. Arveson, Frederic; R. E. Garrison, Wisconsin Rapids; H. E. Kasten, Beloit; N. J. Wegmann, Milwaukee, of the Council; Dr. L. O. Simenstad, Osceola, Society President-Elect; Dr. J. W. Fons, Milwaukee, Speaker; Dr. J. C. Griffith, Milwaukee, Wisconsin AMA delegate; Dr. Gunnar Gundersen, La Crosse, Chairman of the AMA Board of Trustees; Dr. J. S. Supernaw, Madison.

State Bar, Medical Officers Urge Meetings on Inter-Professional Code

Madison—A joint resolution calling for meetings of members of local medical society and bar association groups was signed by the Council Chairman of the State Medical Society and the president of the Wisconsin Bar association.

To start this winter, the sessions will enable members to study the Inter-Professional Code, and to work for further effectiveness of the Code in Wisconsin. Presidents of local groups were asked to arrange for the gatherings.

DRAWS PRAISE

An unusual agreement which has drawn much favorable comment in the country, the Code was adopted by the two state organizations during the past year.

Signed by *Dr. R. G. Arveson* of Frederic, Council Chairman, and *Atty. Alfred E. La France* of Racine, WBA head, the resolution stated:

Whereas, the Wisconsin Bar Association and the State Medical Society of Wisconsin have, by action of their respective governing bodies, adopted and published the Inter-Professional Code to apply to the basic relations between professions; and

CODE IN PUBLIC INTEREST

Whereas, it is the conviction of both organizations that a thorough understanding and full support of the Code by the two professions is in the public interest, inasmuch as it involves substantial and interrelated questions of health and of justice; and that such ends can be best achieved at the local level where the two professions are practiced side by side;

Be it resolved, by the Council of the Wisconsin Bar Association and by the Council of the State Medical Society of Wisconsin, that the president of each local bar association and the president of each local medical society be requested to cooperate in scheduling and holding a joint meeting of all members of their respective organizations during the fall and winter of 1955–56 to study and discuss the Inter-Professional Code and to make it effective in their area; and

Be it further resolved, that copies of this Resolution be circulated among all officers of the local bar associations and medical societies of this state.

REPORT MEDICAL RESEARCH FUNDS TO BE INCREASED

Washington—Secretary of HEW Marion B. Folsom indicated this week the Administration plans to bear down hard on national health legislation in 1956.

There will be no major changes in the program submitted in 1955, he said, though some modification of President Eisenhower's controversial health reinsurance plan is probable.

In a recent TV interview, Secretary Folsom strongly implied that more money would be sought for support of medical research.

This year National Institutes of Health had $97,000,000 for federal grants in aid and intramural studies. It is more than likely the Budget Bureau will raise that by five million, with the biggest portion of the increase going for heart research.

DOCTORS . . .

(Continued from page 33)

service rendered the average patient will be given by doctors employed by the hospital as nurses are."

Loevinger called the complaint about a shortage of nurses "a cliche." He maintained that the number of nurses has been increasing more rapidly than the number of hospital beds or patients and is more than keeping pace with the United States' population.

MORE NURSES

In 1910, there were 55 nurses per 100,000 population and in 1950 there were 249 active professional nurses per 100,000.

On the other hand, he was reported as saying there were 164 physicians for every 100,000 persons in the United States in 1910 and only 128 doctors per 100,000 population in 1950.

Betty Joan Ford, Milwaukee, was named president-elect of the association. The current president is Mrs. Clara Brauer, Wauwatosa. Directors elected were Miss Lorraine Dandoy, Wood; Miss Grace McDermott, Janesville; and Miss Marie Tenneson, Eau Claire.

Sanatorium–Hospital Transfer Law Explained

Madison—Conditions under which a patient in a county tuberculosis sanatorium may be admitted to Wisconsin General Hospital, Madison, were explained by Atty. Gen. Vernon W. Thompson recently.

The opinion was given to Walter T. Norlin, Bayfield County district attorney, who said his county institution was not equipped to handle surgical and post-operative treatment of a TB patient.

Such admittance, Thomson said, is established by law. The sanatorium is to pay the hospital and presumably the surgeon, and state aid is given for the time the patient is temporarily out of the sanatorium, he said.

AMEF Reports Gifts From Wisconsin MD's

Chicago—The American Medical Education Foundation reported this month it had received contributions in October from the following Wisconsin physicians:

Drs. F. J. Cerny, Fond du Lac; Irving I. Cowan, J. C. Peterson and Dexter H. Witte, Milwaukee; J. S. Hess Jr., Mauston and Reon H. Sanders of Stevens Point.

The contributions were transmitted to the National Fund for Medical Education.

Student Loan Plan Developing Favorably

Chicago—Development of a loan foundation for members is progressing favorably, the Student American Medical Association reported.

Once the corporate structure is completed and funds become available, the SAMA Foundation will serve to further one of the objectives for which the organization was founded—the welfare of individual medical students, officers said.

The goal of the Foundation will be to operate as a trust fund for helping worthy, needy medical students meet part of costs for education. Loans will be made at a low interest rate, without collateral, according to present plans.

Formation of the project was announced last June.

Underwriters Salute Doctors at Boston

Boston—The Health and Accident Underwriters' Conference saluted the doctors of America at the AMA clinical sessions early this month.

"These dedicated men and women are the guardians of our health," the Conference said in its tribute. "Doctors are making great strides toward an objective of more and better health."

The Conference said its members had agreed to pay tribute through house organs, bulletin board notices, posters and radio and TV announcements.

Firm Offers Oxygen Therapy Films, Aids

New York—The Linde Air Products Co., is offering a wide selection of films, charts, exhibits, lecture materials, bulletins, handbooks, tags, signs and surveys dealing with oxygen therapy.

These may be obtained, along with any information needed, without cost from the firm's Milwaukee office at 1623 South 38th street.

Films offered include Oxygen Therapy Procedures, Oxygen Dosage and Techniques, Physiology of Anoxia and Oxygen Therapy in Heart Disease, with running time ranging from 22 to 33 minutes.

Medical Vet Society Active in State

Milwaukee—Dr. Stanley Zawodny, Milwaukee, recently was appointed to the steering committee of the National Medical Veterans' Society. This gives Wisconsin two representatives from the organization's steering committee, the other being Dr. Stan Hollenbeck, Milwaukee.

The Milwaukee chapter is the only branch of the society in Wisconsin. Physician-veterans anywhere in the state may join.

SUPPORTED DOCTOR DRAFT

The NMVS has been at odds with the American Medical Association on occasion, largely over continuation of the Doctor Draft which the veterans' society supported. At the same time, this society urged Congress to take steps to make career military service more attractive to physicians.

The positions of the society and the AMA with regard to dependent medical care are about identical. Both believe there should be voluntary participation on the part of military personnel. Both believe that insurance premiums should be collected by allotment from the pay of the military personnel and that their dependents should have free choice of physicians and hospital, except in isolated bases in the United States and nearly all bases outside the United States where, of necessity, military facilities must take care of dependents.

Mental Health Films Available at No Cost

Philadelphia—Films on mental health are available on a loan-cost free basis from the Smith, Kline and French Laboratories, as follows:

Mind and Medicine—A 50 minute filming of a clinical conference sponsored by the AMA and the American Psychiatric Association. It shows 10 case histories of patients before and after treatment with chlorpromazine for professional groups.

Search for Sanity and *We, the Mentally Ill*—two *March of Medicine* telecasts, produced in cooperation with the AMA. These are each 30 minutes, sound, black and white.

Requests should be forwarded to Shirley Winters, Film Center, SKF Laboratories, Philadelphia 1.

1 in 4 Americans Believes Medical Care Costs High

New York—Only 26 per cent of America's adult population believe medical care costs are too high, a national survey disclosed recently.

The figure is from a report released to the pharmaceutical industry by the Health Information Foundation. The study was one of several socio-economic surveys in health initiated by the Foundation.

The findings:

While medical costs in general come in for less criticism than other elements of daily living, within the category of medical costs the percentage believing costs "much too high" for doctors' fees was 16 per cent; hospital charges 39 per cent; dentists' fees 24 and prescriptions at drug stores, 38 per cent.

When asked "What are some of the things that make it easier to have good health today than it was 30 years ago?" 71 per cent cited improvements in medical knowledge and facilities and 47 per cent specifically referred to new drugs, medicines and vaccines.

SAY COSTS HIGH

Thirty-eight per cent believe the costs of precriptions are "much too high," and 28 per cent said the costs are "somewhat higher" than they should be. The druggists were blamed for the high costs on 26 per cent of the questionnaires, the doctors 10 per cent of the time.

OFFER SAFETY KITS, TAPES

Madison—Looking for program material on home safety?

The Wisconsin Safety Council's subcommittee on home safety is offering a *"Community Home Safety Program Kit."* It includes workable program suggestions, sample pamphlets, film lists, exhibit ideas and other aids.

Address your request for the kits to Wisconsin Council of Safety, Room 234, State Office Building, Madison 2. There is no charge.

Radio tapes, ranging in length from five to 15 minutes, are available through the State Board of Health, Health Education Division, Madison 2. Each one stresses home safety, and presents a dramatic message of value.

Minutes of the Council Meeting, Milwaukee May 4, 1955

The Council was convened in special session by reason of referral to it by the House of Delegates of the secretary's special report relating to the Principles of Medical Ethics and the position taken by the Wisconsin Pharmaceutical Association.

The meeting was called to order by Chairman Arveson at 1:00 p.m., Wednesday, May 4, in Milwaukee.

Councilors present were Doctors James, Lokvam, Kasten, Heidner, McCarey, Garrison, Arveson, Bernhart, Wegmann, Curran, and Past-President Tenney. Also present were Speaker Fons and Drs. S. E. Gavin, D. H. Witte, W. D. Stovall, and J. C. Griffith, delegates to the American Medical Association.

Staff members present were C. H. Crownhart, secretary; Misses Pyre and McGruer; and Robert B. Murphy, legal counsel.

Chairman Arveson called upon the secretary to summarize the report as presented Monday evening, May 2, to the House of Delegates. After discussion of the subject by the secretary there was discussion by individual members of the Council and A.M.A. delegates, with final action being upon motion of Doctors Curran–Heidner, carried, that the report of the secretary be referred with the endorsement of the Council to the Wisconsin delegation to the American Medical Association for appropriate action.

Following further discussion on the organization of the A.M.A. and of the State Medical Society, the meeting was adjourned at 3:30 p.m.

C. H. Crownhart
Secretary

Approved:
R. G. Arveson, M. D.
Chairman of the Council

Minutes of the Council Meeting, Land O'Lakes July 30-31, 1955

1. Call to Order

The Council was called to order by Chairman Arveson at 9:40 a.m., Saturday, July 30, at Land O'Lakes, Wisconsin.

2. Roll Call

Councilors present were Doctors James, Lokvam, Hill, Kasten, Heidner, Bell, Garrison, Arveson, Ekblad, Galasinski, Bernhart, Conway, Curran, and Past-President McCarey.

Also present were Speaker Fons; Vice-Speaker Kief; Drs. S. E. Gavin, D. H. Witte, W. D. Stovall, and J. C. Griffith, delegates to the American Medical Association; J. S. Hirschboeck, M. D., Dean of Marquette University School of Medicine; J. Z. Bowers, M. D., Dean of the University of Wisconsin Medical School; C. N. Neupert, M. D., state health officer; and J. M. Sullivan, M. D., chairman of the Society's Committee on Public Policy.

Other special guests were the following members of the Council on Scientific Work: Drs. P. A. Midelfart, S. A. Morton, M. G. Rice, Kenneth Lemmer, M. F. Huth, and R. S. Baldwin.

Staff members present were C. H. Crownhart, secretary; R. T. Ragatz, Earl R. Thayer, and W. C. White, Jr., assistant secretaries; Robert B. Murphy, legal counsel; and Frances Wermuth and Jean McGruer of the Society's office.

3. Approval of Minutes

On motion of Doctors McCarey–Kasten, carried, approval was given to the minutes of the February, 1955, annual meeting of the Council, as published in the May, 1955, issue of *The Wisconsin Medical Journal.*

4. Introduction of Guests

Chairman Arveson welcomed as special guests Dr. J. S. Hirschboeck, Dean of the Marquette University School of Medicine; Dr. John Z. Bowers, new Dean of the University of Wisconsin Medical School; Dr. S. A. Morton, chairman of the Council on Scientific Work; and members of that committee. In greeting the guests, Doctor Arveson pointed out that the special themes of the July meeting were medical education and scientific medicine, and that the Council on Scientific Work had been asked to join with the general Council to discuss plans for the 1956 Annual Meeting.

5. Introduction of New Business

Dr. R. E. Galasinski, Milwaukee, stated that the matter of patient privilege and physician release of information had been brought to his attention, and he requested that the subject be placed at the foot of the agenda.

6. Emergency Consultation Committee

On motion of Doctor Galasinski, variously seconded and carried, the Council confirmed its mail ballot on recommendations of the Emergency Consultation Committee in connection with the Salk vaccine against poliomyelitis, made on July 10, 1955. It was reported that as the result of the mail ballot approving the recommendations, copies of them had been mailed to the membership on July 19.

7. 1956 Annual Meeting

The Council on Scientific Work met in conjunction with the general Council, so that recommendations for the 1956 Annual Meeting might be presented to it. Dr. S. A. Morton, general chairman of the Council on Scientific Work, made the following report on its behalf:

"Mr. Chairman and members of the Council—I think that we must all agree that one of the prime functions of the State Medical Society of Wisconsin is to provide continuing scientific education to its members.

"Over the years, your Council on Scientific Work has tried to do just that; and by its 'circuit teaching' programs, and by its Annual Meeting, it has endeavored to present recent advances in medicine to the doctors of the state.

"In spite of our best efforts, there seems to be a declining, or at least a stationary, interest in the scientific programs of our Society. This is not unique to us here in Wisconsin; a similar problem has arisen in most state societies. The reasons for this are many, and are bound up with the thought that there are too many medical meetings, and that there is an increasing diversity of interest among our members. These are things that have occurred in the evolution of medicine and we can do little about them. We must accept them and try to make our programs as attractive as possible to our members.

"With this in view, then, we would like to offer the following suggestions and comments for your discussion and perhaps further action:

"1. The Council on Scientific Work feels that the matter of publicity and promotion of our meetings is not entirely its function. We will prepare the best program that we can, but we feel that the Council and officers of the Society should share in some degree in the promotion of our meetings.

"2. We feel that close cooperation with the Wisconsin Academy of General Practice in the planning of our programs is to be desired, in the hope that our meeting can be designated as a formal teaching meeting for which its members may receive credit. A direct participation by this group in the planning of part of our programs is needed if this end can be accomplished.

"3. It is not the intent of your council to go back to sectional meetings at our annual session, but several of the specialty groups—for example, the ophthalmologists and the anesthesiologists—have expressed a desire to hold their meetings in conjunction with ours. It is therefore planned to set aside one afternoon when these groups can meet. The various special societies will be contacted to see how much cooperation with us they desire. The SMS office could take care of their publicity, even though it went out over the signatures of their own officers.

"4. The speakers at our meetings would be urged to adopt an informal manner of presentation, and the avoidance of closely read papers would be stressed.

"5. In next year's program it is planned to extend more widely the use of panel discussions, symposia, and round-table methods of presentation.

"6. The cooperation of the Council and officers is earnestly solicited, so that there will be no, or at least a minimum of, conflicting meetings of the delegates and committeemen during the time of our scientific assemblies.

"7. As a result of holding our meeting in Milwaukee, we get excellent attendance from the medical students from Marquette. The Council on Scientific Work would like your reactions on perhaps bringing the seniors, or even the junior students, at the University of Wisconsin to the meeting on buses chartered by the Society.

"8. Your council views with concern the unfavorable reaction of the exhibitors toward our meeting, and we feel that the members should be urged by the Council and officers to visit the exhibits more widely and to register at the booths. The rent that these exhibitors pay goes a long way toward financing our meeting, so we should show more interest.

"9. It has been suggested that a special program be directed to the new members of the Society. The council is planning, subject to your approval, to conduct a round-table luncheon, to which the new members will be invited by special invitation. It is hoped that the president and other officers of the Society will attend, to meet the new members and to explain to them the purposes and workings of our Society.

"To continue the program of indoctrination of these new members, it is proposed to have a paper, on the same day, on some medico-legal or medico-economic topic, such as malpractice insurance or the medical aspects of insurance.

"10. Your council is aware of the influence that the doctors' wives may have in the attendance of the doctors at our Annual Meeting. We would suggest to the Council that an effort be made to strengthen the program of the Auxiliary at the annual session, and that some of our staff work with their officers with this end in view. It is further suggested that some of our speakers might be used on the Auxiliary program.

"11. The suggestion has been made that a 'hobby show' be held in connection with the Annual Meeting. Your council does not favor this.

"12. You recently have received notices of the 'circuit programs' planned for next year. The Coun-

cil on Scientific Work urges the cooperation of the officers and councilors of the various districts to the end that conflicting meetings be avoided and, if possible, county meetings be held in conjunction with the circuit program.

"13. Let me remind you that one of the functions of the Council on Scientific Work is the publication of our *Wisconsin Medical Journal*. Our editor, Doctor Baldwin, is with us; and perhaps you would like to hear from him.

"The Council on Scientific Work is deeply appreciative of the support of the general Council in its work and gratefully acknowledges the help it has received from the members of the Society office in Madison. We are a committee working under your direction; and we are eager to receive your suggestions, your comments, and your help."

After considerable discussion, and various suggestions, and on motion of Doctors Galasinski–Ekblad, carried, the report of the Council on Scientific Work was accepted in total, with an expression of appreciation to the council for its substantial contribution.

On further motion of Doctors Kasten–Hill, carried, the Council approved a proposal offered by the speaker and vice-speaker of the House of Delegates, that there be a meeting of all new delegates and alternates, reference committee chairmen, the speaker, and vice-speaker prior to the first session of the House, and that this be an annual affair, by invitation only.

An item on the agenda was a proposal of the Council on Medical Service, forwarded to the Council on Scientific Work, that a special meeting be held during the course of the Annual Meeting for new members of the Society, topics for which would be primarily in the medical-economic field. It was pointed out that this item was already covered by approval of the report of the Council on Scientific Work.

8. Circuit Teaching Programs

The "circuit" teaching programs have long been one of the primary scientific efforts of the Society. It was pointed out that an immense amount of staff time is required in their planning, but in recent years the total cost to the Society has been relatively insignificant, as various outside agencies, such as the State Board of Health, Wisconsin Heart Association, and American Cancer Society, have contributed to the expense of speakers. Question had been raised as to the continuance of these programs in light of the often-heard statement "too many medical meetings."

On motion of Doctors Garrison–Hill, carried, the Council voted continuation of this type of teaching program, recommended that county societies in the immediate vicinity accept such program in lieu of a program for one of their own meetings, and approved continuation of the financing as described.

9. Medical–Dental Postgraduate Programs

In 1953, in cooperation with the Wisconsin Division of the American Cancer Society, the Committee on Cancer of the State Medical Society sponsored a series of clinics for physicians and dentists on the subject of cancer. While the subject of oral cancer was given primary attention, other portions of the programs concerned themselves with cancer of the lungs, cancer of the female genital tract, and skin cancer.

These clinics have been held every year since 1953, and in all of the meetings the program has emphasized the joint responsibility of the allied professions in the early detection of cancer, and the unusual opportunities afforded both dentists and physicians to make contributions to the cancer control program.

Dr. W. D. Stovall, Madison, addressed the Council on the subject, expressing the belief that these meetings were invaluable public health efforts and were particularly helpful in promoting good interprofessional relations with doctors of dental surgery. He felt that their success was unquestioned.

On motion of Doctors Garrison–Hill, carried, continuation of these programs was approved.

10. National and Regional Meetings in Wisconsin

Such national or regional meetings as have been held in Wisconsin have been more or less at the choice of the organizations concerned and dependent in large part upon the interest of their Wisconsin members. The staff had considered the advisability of undertaking an active program of promoting various national and regional meetings in this state, providing, within reasonable limits, staff and publicity assistance.

There was a discussion of the matter by Mr. Thayer, of the Society's office, and various members of the Council, after which, on motion of Doctors Lokvam–Galasinski, it was stated, as a policy of the State Medical Society, that where programs of national and regional character could be accommodated within this state, staff assistance should be made available within reasonable limits, to aid in their promotion.

11. Councilor District Meetings

Councilors and officers are well aware of the varying patterns of councilor district organizations. For quite some period the Society offered to prepare scientific programs for such meetings, but only four or five of the districts took advantage of the opportunity. Consequently, this assistance was discontinued.

Doctor Kasten expressed the belief that district meetings should be of medical-legal and economic nature; and on his motion, seconded by Doctor McCarey, this was stated as the policy of the State Medical Society.

12. Medical–Legal Institutes

In 1954 the Society provided substantial cooperation in the development of a midwinter medical–

legal institute for the membership of the Wisconsin Bar Association. The program was highly successful and the attendance approximated 600 attorneys, with some physicians also attending.

In 1955 the Bar Association felt that it would like to make the medical–legal institute the circuit type of program, and again the Society provided substantial assistance, receiving editorial praise from the then-president of the Association.

In a discussion of the subject, the staff reported that there had been no separate financing provided by the Medical Society, and its contribution had been essentially a matter of staff time and a limited amount of facilities.

Doctor Ekblad pointed out that there had been such a meeting within his district and felt that development of these institutes at a county level was of substantial value. He expressed the belief that the Society should endorse and promote this type of institute; and on his motion, seconded by Doctor Heidner and carried, this type of promotion was authorized.

13. Prematurity Clinics

Mr. Ragatz, of the Society's office, presented the subject, and said that continued study of the problems of prematurity had emphasized the need for a "team" approach of physicians and nurses. With this in mind, the Division on Maternal and Child Welfare requested the Maternity Pavilion, Milwaukee Hospital, and St. Mary's Hospital, Madison, to set up teaching programs for representatives of hospital medical and nursing staffs. Drs. Kenneth Winters, Milwaukee, and T. V. Geppert, Madison, were in charge of two-day programs of lectures and demonstrations.

It was reported that initially, because of the need for close observation and restricted quarters, enrollment was limited to four physicians and four nurses at each institute. Four such institutes were held in 1954; later the maximum enrollment was increased to eight physicians and eight nurses, and four such institutes had been held to date in 1955.

After further discussion, and on motion of Doctors McCarey–Hill, carried, the Council authorized continuation of the prematurity clinics.

14. Interpretation of Maternal Mortality Study, 1953

As a means of summarizing the significant findings of the Maternal Mortality Study for the year 1953, the Study Committee prepared a set of slides which provided statistical information on the most significant causes of death related to obstetrical care. A speakers' bureau has been made available to hospital staffs and county societies.

On motion of Doctors Bell–Galasinski, carried, continuation of the maternal mortality presentation, as described, was approved.

15. Report of Committee on Medical Practices of the A.M.A.

There was general discussion of the summarized report of this committee, which had been submitted to the meeting of the A.M.A. in June, but without distribution of the complete report.

Councilors and officers were informed that the report placed considerable emphasis on the lack of understanding by the public and the profession of ethical considerations and problems, and emphasized the urgency of re-establishing medicine's position as a self-disciplinary group.

On motion of Doctors Heidner–Hill, carried, copies of the report, when available, were authorized to be distributed to county medical societies, specially organized societies, and appropriate committees within the structure of the State Medical Society.

A proposal that the Society sponsor a series of lectures for medical students on the Principles of Medical Ethics, and another proposal that there be a study of the feasibility of further developing courses in legal medicine, were referred to the Committee on Medical Education and Hospitals for consideration.

16. Osteopathy

The Wisconsin delegation to the American Medical Association presented a discussion that was held at the June, 1955, meeting of the A.M.A. with reference to osteopathy. The apparent conclusion of the meeting was that the osteopathic schools had not removed cult teaching entirely from their courses. The action of the A.M.A. was to defer further consideration until approached by the American Osteopathic Association.

In light of developments at the A.M.A. meeting, the Council, on motion of Doctors Heidner–McCarey, carried, reaffirmed its statement of ethical considerations adopted at its February, 1950, meeting, as shown in the minutes of that session.

Doctor Lokvam then inquired as to the status of osteopathic schools under the revised Medical Practice Act, and stated that in his judgment, in light of the special report submitted to the A.M.A., further inquiries should be made.

On motion of Doctors Ekblad–Garrison, carried, it was agreed that this subject should be re-examined.

At this point in the meeting, the Council recessed until 10:00 a.m., Sunday, July 31.

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17. Optometry

The Council considered resolutions adopted at the June, 1955, meeting of the A.M.A. applying to the practice of optometry, one such resolution holding it to be "unethical for any doctor of medicine to teach in any school or college of optometry, or to

lecture to any optometric organization, or to contribute scientific material to optometric literature, or in any way to impart technical knowledge to nonmedical practitioners." Another resolution was the request that suitable criteria be established by the A.M.A. to govern referrals from optometrists to ophthalmologists.

There was general discussion. It was agreed that clarification of these actions would probably be required; and, in light of this, it was moved by Doctors Kasten–Conway, carried, that the subject be laid over for further consideration within the committee structure of the State Medical Society.

18. Anti-Public Health Movements

The attention of the Council was directed to various campaigns against fluoridation and similar accepted public health programs. It was pointed out that organized opposition seemed to stem from those adhering to cult practices; and on motion of Doctors James–Garrison, carried, the staff was instructed to study the subject and to present a further report to the Council at a subsequent date.

19. Patient Privilege

Doctor Galasinski's request for discussion of this new topic was next considered, and there was general discussion of the law of privilege as it relates to medical licensure, the Workmen's Compensation Act, and similar matters. The secretary's staff was instructed to study this subject in greater detail, reporting back to the Council at a later meeting.

20. Prepaid Insurance

Doctor Lokvam requested permission to present a topic not on the agenda. He stated he felt there was a considerable amount of misunderstanding with reference to the extent to which various insurance plans actually provided coverage, and that in their promotion, purchasers were led to the belief that the plans were most comprehensive without consideration of the fact that there were many exclusions as to circumstances or benefits. He stated his belief that this created unwarranted problems for practicing physicians, inasmuch as many times physicians were themselves blamed for these difficulties.

The Chairman of the Council expressed his opinion that the topic more properly belonged with the Commission on Prepaid Plans and that Doctor Lokvam should discuss the subject there. Without objection it was so ordered.

21. Agency Agreement with Blue Cross

The Commission on Prepaid Plans recommended Council approval of an amendment to the Agency Agreement with Blue Cross which, in substance, eliminates the requirement of a Wisconsin Physicans Service bank account in the Marshall & Ilsley Bank, Milwaukee, sufficient to provide earnings at least equal to the WPS share of bank service charges. Mr. White, of the Society's office, pointed out that under the amendment Blue Cross will bill WPS for its prorated share of such charges at the rate of .0009 cents per contract per month.

On motion of Doctors Galasinski–Ekblad, carried, the Council approved the recommended amendment to the Agency Agreement.

22. Dedication Ceremonies, New Building

It was reported that Dr. W. D. Stovall and Earl Thayer were working out plans for dedication of the new building on October 15, but that all plans had not been crystallized.

On motion of Doctors Kasten–Ekblad, carried, Doctor Stovall and Mr. Thayer were given full authority to work out final details and plans for the ceremony.

23. Society Flag

It had been suggested that the Society's meetings in large auditoriums (such as the Annual Meeting) might be given a great deal more dignity, in keeping with traditions of the profession, if the speaker's rostrum or table could have the seal of the Society as a backdrop.

Mr. Thayer presented a suggested type of banner, which was approved on motion of Doctors Bernhart–Bell, carried.

24. Report of the Executive Committee

a. Scientific Foundation

The Executive Committee is pleased to report to the Council that more than 325 physicians have responded to the initial billing in behalf of the Scientific, Educational, and Charitable Foundation, and that receipts in the account of that Foundation are probably, at this point, in excess of $4,000.

Because of pending applications for student loan funds and a necessary delay in completing the organization of the Foundation, the Executive Committee recommends to the Council that immediate authority be granted to handle existing applications, funds for which are well within the total already received.

The Executive Committee further recommends to the Council that it direct a communication through the secretary to all county medical societies, asking those organizations to promptly determine the individual trustees representing their societies. With the completion of the trustee organization, a meeting of the entire group will subsequently be called.

On motion of Doctors Bernhart-McCarey, carried, this portion of the report was approved.

b. The Executive Committee reviewed a number of administrative problems in connection with the operation of the new building, and mechanisms have been devised for further reports which will subsequently come before the Council.

An interesting history of the property has been developed, and the Executive Committee has authorized its publication in *The Wisconsin Medical Journal* in such form that reprints may be made available for those who desire them.

The Executive Committee has approved the scheduling of a meeting in October of the Midwest Medical Conference, at which will be present the principal officers of state medical associations in the states of Indiana, Michigan, Illinois, Kentucky, and Wisconsin. Wisconsin will serve as host state to this group of approximately 20 to 25 individuals; they will meet in the new building in informal fashion to consider matters of mutual interest.

The Interprofessional Institute, organized by the State Medical Society a year ago, will be scheduled during the ensuing months, with the president of the Society as the presiding officer and in charge of the program.

c. Annual Meeting invitations to the principal officers of the A.M.A. have been authorized. Also, plans are being developed for various study projects which, when cleared by the Executive Committee, will be referred to the Council for formal consideration. Among these are an organized program for the education of our membership with reference to prepayment plans, informative material concerning the distribution of health personnel and facilities, and the development of similar matters.

d. One of the most important matters in the Executive Committee's report is the recommendation relative to the State Board of Health and various public health laws of this state. These are many and complicated—in some cases antiquated, and in others vague and uncertain. Staff members of the Governor's office have indicated their belief that it is of pressing importance that a coordinated project be undertaken to modernize certain phases of these laws.

Since there is such an excellent cooperative relationship between the State Board of Health and the State Medical Society, it is proposed that the two organizations jointly study the structure of several outstanding state health departments, and with that background then develop a long-range program to meet the recommendations of government officials. This is not a project that can be completed within the immediate future. The Executive Committee recommends that the Council authorize the development of this project.

On motion of Doctors Bernhart–Conway, carried, Council authorization was given to the project.

e. Finally, there were other matters considered, among them the development of adequate definitions of narcotic and dangerous drugs, the status of corrective therapists under the physical therapy law, the ability of the medical profession to implement a medical examiners system if and when enacted, and publicity attendant upon the substantial changes recently accomplished in the commitment laws. Action on these matters will all be duly reported to the Council, the Executive Committee and the Committee on Public Policy having confirmed further activity in these respects.

This section of the report was adopted, on motion of Doctors Bernhart–Ekblad, carried.

25. Adjournment

There being no further business, the Council meeting was adjourned at 11:30 a.m., Sunday, July 31, 1955.

C. H. Crownhart
Secretary

Approved:

R. G. Arveson, M. D.
Chairman of the Council

Minutes of the Council Meeting, Madison October 14, 1955

1. Call to Order

The first meeting of the Council at the new State Medical Society building was called to order by Chairman Arveson at 2:15 p.m., Friday, October 14, 1955.

2. Roll Call

Councilors present were Doctors James, Hill, Kasten, Dessloch, Heidner, Carlson, Fox, Bell, Garrison, Arveson, Ekblad, Galasinski, Bernhart, Conway, Curran, and Past–President McCarey.

Also present were President-Elect Simenstad; Speaker Fons; Vice-Speaker Kief; Drs. S. E. Gavin and W. D. Stovall, delegates to the American Medical Association; Dr. Gunnar Gundersen, member of the Board of Trustees of the American Medical Association; Dr. Carl Neupert, state health officer; Dr. Robert Moore, member of the Commission on Prepaid Plans; and Mr. R. R. Rosell, secretary of the Minnesota State Medical Association.

Staff members and consultants present were C. H. Crownhart, secretary; E. R. Thayer and W. C. White, Jr., assistant secretaries; T. J. Doran, claims director; Robert B. Murphy and S. E. Gavin, Jr., legal counsel; and Misses Joan Pyre and Jean McGruer.

3. Special Remarks

In calling the meeting to order, **Chairman Arveson** said:

"Gentlemen, this is a memorable event, as it is the first meeting of the Council in our new building. One of our members spoke to me, saying that he would like to make some remarks at this time. I want to call upon Dr. Nels Hill."

Doctor Hill: "We're meeting here for the first time, and I think we should give credit where credit is due, and therefore I wish to move that the Council express its appreciation for the vision and foresight of Mr. Crownhart in selecting the site of this building; further, that he be commended for his patience and for his approval of the needs that must be fulfilled by the building; also his careful planning for future needs and development; even more, for the tireless attention to details as the building progressed. All of these efforts have resulted in this beautiful and useful structure. The staff which has so faithfully cooperated under exceedingly trying circumstances deserves commendation and recognition to an equal extent for our present use and occupancy of this new headquarters."

The motion was seconded by Dr. R. E. Garrison, and unanimously carried.

Doctor Arveson: "Mr. Crownhart, I know we are all very happy, and I know you are happy with this building; much of it has been due to you. But there are some other men who could well be mentioned here—Eli Dessloch, Nels Hill, and Kent Tenney, who served as the building committee, and others as well.

"At this time I should also like to welcome back Dr. Jim Fox, councilor from La Crosse. It's nice to have you here."

4. Introduction of New Business

Councilor Dessloch asked that as new business there be considered the matter of providing a mechanism of approbation for those radio stations carrying the March of Medicine. The subject was placed at the foot of the agenda.

5. Proposed Joint Resolution, Wisconsin Bar Association and the State Medical Society of Wisconsin

By formal action of the council of the Wisconsin Bar Association, the Council of the State Medical Society was requested to enter joint resolution with it. That resolution follows:

"WHEREAS, the Wisconsin Bar Association and the State Medical Society of Wisconsin have, by action of their respective governing bodies, adopted and published the Interprofessional Code to apply to the basic relations between professions; and

"WHEREAS, it is the conviction of both organizations that a thorough understanding and full support of the Code by the two professions is in the public interest, inasmuch as it involves substantial and interrelated questions of health and of justice; and that such ends can best be achieved at the local level where the two professions are practiced side by side;

"*Be it resolved*, by the Council of the Wisconsin Bar Association and by the Council of the State Medical Society of Wisconsin, that the president of each local bar association and the president of each local medical society be requested to cooperate in scheduling and holding a joint meeting of all members of their respective organizations during the fall and winter of 1955–56 to study and discuss the Interprofessional Code and to make it effective in their area; and

"*Be it further resolved*, that copies of this Resolution be circulated among all officers of the local bar associations and medical societies of this state."

WISCONSIN BAR ASSOCIATION
September —, 1955.
ALFRED E. LAFRANCE, *President*

STATE MEDICAL SOCIETY OF WISCONSIN
October —, 1955.
R. G. ARVESON, M. D.
Chairman of the Council

On motion of Doctors Hill–Galasinski, the resolution was unanimously adopted.

6. Wisconsin Medical Journal

There was discussion with reference to the publication policy of the Journal relating to scientific articles. It was generally understood that the medical editor is granted authority to select appropriate scientific articles, but that the Council retains, under the Constitution and By-Laws, the final responsibility for the publication policy of the Journal. On reference of the medical editor it was determined that certain papers, while appropriate for presentation in specialty publications, and before other groups, were not in themselves original contributions to the Journal. On motion of Doctors Bell–McCarey, carried, this policy was affirmed.

7. Wisconsin Veterans Medical Service Agency

The major problem confronting the agency in its administrative affairs relates to the volume of authorizations in the field of psychiatric attention. Therefore, the Operating Committee of the VMSA requested that the Council take action to enlarge the committee by two members who may provide assistance in this specialized field.

On motion of Doctors Ekblad–Kasten, carried, the request of the committee was approved, with authority in the chairman to make such appointments.

8. Special Report, Veteran Care

Dr. James P. Conway, Milwaukee, reported on a special meeting with respect to veteran care, held in Indianapolis on September 27. Several Wisconsin physicians were present, together with representatives of the American Medical Association, the American Legion, the Veterans Administration, and the American Hospital Association.

Doctor Conway said he felt that many of the difficult areas between medical and veteran groups were discussed, and that this in itself contributed to better understanding.

At the meeting Doctor Middleton, chief medical officer, gave an excellent summary of the VA Medical Department's position and indicated his desire to continue and expand the resident training programs of the VA.

Doctor Conway pointed to a rather general feeling that future meetings on the problem of veteran care should involve not only representatives of medicine and the American Legion, but individuals from the dental and hospital groups.

9. Commission on State Departments

a. The Commission reported to the Council that there are a number of organizations, quite often composed of both laymen and physicians, organized to study public health problems such as diabetes, mental hygiene, heart conditions, etc. Some of these organizations have established liaison with various state departments and have asked for advisory committees of the medical profession.

Because these organizations may deal with the identical subjects within the jurisdiction of the Commission on State Departments, the Commission recommended that it be given authority to advise with such organizations at such times and under such arrangements as may seem advisable.

> The recommendation was approved by the Council on motion of Doctors Dessloch–Curran.

b. The Commission reported further that the increasing number of motor vehicular collisions and health problems associated with such matters as drivers' licenses, accident reports, etc., prompted it to recommend that the Council amend its action of November, 1952 (*Wisconsin Medical Journal*, vol. 51, p. 1228), to create as a tenth division that on highway safety, which would be advisory to the Motor Vehicle Department.

> On motion of Doctors Bell–Dessloch, carried, the recommendation was approved and the election of a chairman of the division was placed at the foot of the agenda.

10. Student Loan Fund and the Charitable Foundation

Acting as the executive committee of the board of trustees of the Charitable Foundation, the Council approved pending applications to the Student Loan Fund, on motion of Doctors Dessloch–Curran, carried.

The secretary then stated that he felt it was important to consider the future total operation of the Foundation in preparation for a full meeting of the board of trustees in May, 1956. He said that he foresaw the possibility of certain other activities in addition to the making of student loans, activities directly in the public health interest. He pointed out that there was increasing concern on the part of voluntary insurance organizations as to how best to extend protection of insurance to the upper age brackets and in those fields which might ultimately involve public assistance areas.

He stated his belief that while there was much interest on the part of individual organizations, a grouping of that interest through the Foundation and arrangements for the financing of special studies relating primarily to Wisconsin might ultimately be developed. He said that if such would be the case, the details would be brought back to the trustees for formal approval, but unless there was objection on the part of the Council, he would explore these possibilities further, it being understood they were at best only tentative ideas which had not been crystallized to any extent.

There was general discussion, followed by agreement that the secretary had authority to proceed as requested.

11. Interprofessional Relations and Pharmacy

The secretary pointed out that at the July, 1955, meeting of the Council, he and legal counsel had been authorized to prepare a general outline of a constructive program to bring about a better understanding of the mutual responsibilities, problems, and policies of the medical and pharmaceutical professions.

As the first step in that direction the secretary proposed republication in *The Wisconsin Medical Journal* of an editorial recently appearing in the *Journal of the American Judicature Society* entitled "A Little Learning," which bore upon the subject of individuals not licensed as attorneys seeking to engage, in a limited way at least, in what the Judicature Society felt would be the practice of law. He proposed a parallel editorial to be entitled, "Res Ipsa Loquitur," the essential point being that in repeated public health invasions, the medical profession stood virtually alone in defense of the credulous sick, and pointing out that one group which could well extend cooperation in that activity would be the pharmacists, whose interest in public health should be no less than that of the medical profession. Publication of the editorial was approved.

The secretary stated that if there were general agreement by the Council, he would develop in further detail other suggestions, including representation that many complaints of the Wisconsin Pharmaceutical Association directed to the activities of employees of the physician assumed the application of pharmacy laws which, generally speaking, are inapplicable to the physician in his practice of medicine; and if complaint does have appropriate standing, state officials should be concerned to the point of making clear what jurisdiction exists between enforcement agencies.

In addition, the secretary analyzed the published position of the Wisconsin Pharmaceutical Association on the matter of counter dispensing, and felt that it was based on erroneous concept of both fact and law, as well as of the professional ethics of the Pharmaceutical Association.

These and other matters were presented, with action being to approve the outline as presented, it being understood that specific programs, edito-

rials, legislation, resolutions, articles, and studies would be brought back to the Council for final authorization.

12. Resolutions of Commendation

On motions variously made, seconded, and unanimously carried, the Council adopted resolutions commending the Wisconsin Division of the American Automobile Association, the Wisconsin State Highway Department, the architect, and others.

13. Congratulations from the Medical Society of Milwaukee County

Dr. J. W. Fons, Milwaukee, president-elect of the Medical Society of Milwaukee County and speaker of the House of Delegates, presented the following statement on behalf of the county society:

"May I, as president-elect of the Medical Society of Milwaukee County, extend to this Council greetings from its board of directors, sincere congratulations upon the completion of this beautiful edifice, and best wishes for continued success and cordial relations."

14. Proposed Cancer Program

This subject was discussed by Dr. W. D. Stovall, who stated it is proposed that the U. S. Public Health Service will train in the State Laboratory of Hygiene technicians in desquamative cytology of cancer. Following such training, a survey of four or five counties will be conducted concerning the occurrence of cancer of the cervix and uterus, it being planned to survey approximately 160,000 women over 20 years of age. County medical societies would be requested to approve studies in their areas. The Society's Committee on Cancer recommended approval of the program.

Council approval was given on motion of Doctors Dessloch–Kasten, carried.

15. Sponsorship of the Industrial Institute on Alcoholism

The Council was reminded that the previous institute was approved by the State Medical Society. Endorsement of the institute to be held in March, 1956, was requested; and the Council authorized the Society to act as a sponsor.

16. New Business

a. Doctor Dessloch presented further his proposal to recognize radio stations whose cooperation in broadcasting the March of Medicine program represented a sound public health contribution. After discussion, it was duly moved, seconded, and carried that the development of an appropriate plaque be referred to the Council on Medical Service, and that in arranging for its award, officers of county medical societies and councilors be included.

b. The secretary directed the attention of the Council to its earlier action creating a new division of the Commission on State Departments with reference to highway safety and to serve in an advisory capacity to the Motor Vehicle Department.

Dr. N. A. Hill, Madison, nominated Robert S. Gearhart, M. D., Madison, to head this division and to be a member of the Commission on State Departments. There being no further nominations, on motion of Doctors Hill–Ekblad, carried, nominations were declared closed and the secretary instructed to cast the unanimous ballot of the Council for Doctor Gearhart.

17. Adjournment

There being no further business, the meeting was adjourned at 4:30 p.m., Friday, October 14, 1955.

C. H. Crownhart
Secretary

Approved:

R. G. Arveson, M. D.
Chairman of the Council

UNIVERSITY OF FLORIDA MIDWINTER SEMINAR IN OPHTHALMOLOGY AND OTOLARYNGOLOGY

The tenth annual University of Florida midwinter seminar in ophthalmology and otolaryngology will be held at the Sans Souci Hotel in Miami Beach the week of January 16, 1956. The lectures on ophthalmology will be presented on January 16, 17, and 18, and those on otolaryngology on January 19, 20, and 21. A midweek feature will be the midwinter convention of the Florida Society of Ophthalmology and Otolaryngology on Wednesday afternoon, January 18, to which all registrants are invited. The registrants and their wives may also attend the informal banquet at 8 p.m. on Wednesday. The schedule has been arranged to provide a maximum time for recreation each afternoon.

The seminar lecturers on ophthalmology this year are Dr. Francis H. Adler, Philadelphia; Dr. A. Gerard DeVoe, New York; Dr. Michael J. Hogan, San Francisco; Dr. C. Wilbur Rucker, Rochester, Minnesota; and Dr. A. D. Ruedmann, Detroit, Michigan. Those lecturing on otolaryngology are Dr. Frederick A. Figi, Rochester, Minnesota; Dr. Lewis F. Morrison, San Francisco; Dr. Charles E. Kinney, Cleveland; Dr. John R. Lindsay, Chicago; and Dr. Bernard J. McMahon, St. Louis.

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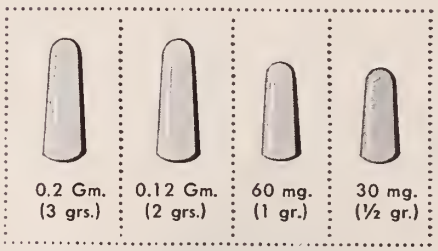

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Society Proceedings

Barron–Washburn–Sawyer–Burnett

The Barron–Washburn–Sawyer–Burnett County Medical Society met on November 8 at the Elks Club, Rice Lake, and heard a talk by Dr. John Feuling on "Treatment of Fractures in General Practice." Doctor Feuling is an orthopedic surgeon from Duluth, Minnesota. Fourteen members of the society were present at the meeting.

Brown–Kewaunee–Door

When the Brown–Kewaunee–Door County Medical Society met at the Elks Club in Green Bay on Thursday, November 10, Mr. J. Henricks of Baxter Laboratory discussed "Milliequivalent and Fluid Balance." A film, "Role of the Ion," was also shown.

Chippewa

Members of the Chippewa County Medical Society elected new officers at their meeting, October 3 at the Hotel Northern, Chippewa Falls. *Dr. Frank Brown* of Chippewa Falls was elected president; *Dr. W. F. Jane*, also of Chippewa Falls, vice-president; and *Dr. B. J. Haines*, Cadott, secretary-treasurer.

Dane

Dr. J. Burns Amberson, professor of medicine emeritus, Columbia University, New York, spoke on "Pneumonia Related to Bronchial Carcinoma" at the November 8 meeting of the Dane County Medical Society which was held at the Veterans Hospital Auditorium in Madison.

The meeting was the annual Dearholt Day program; and *Dr. Robert Gearhart*, newly elected president of the Dane County Medical Society, presided.

Fond du Lac

On November 17, members of the Fond du Lac County Medical Society met at the Elks Club in Fond du Lac. Guest speaker was Dr. John Z. Bowers, dean of the University of Wisconsin Medical School, who spoke on "Arthritis and Medical Education."

Kenosha

Thirty-seven members of the Kenosha County Medical Society met at the Elks Club, Kenosha, on November 3. Guest speaker was *Dr. George H. Jurgens*, Milwaukee, who discussed "Differential Diagnoses of Pulmonary Diseases."

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In a business session, it was decided that the Industrial Health Committee would meet with representatives from industry and report its findings at the next meeting. The committee also will make a review of the county fee schedule.

Oconto

On October 18, members of the Oconto County Medical Society met at the Fireside Club, Oconto Falls. Two movies were presented, one on hypertension and the other on malignant oral tumors.

Election of officers was held. *Dr. A. F. Slaney* assumed the office of president, *Dr. George Mohler* that of president-elect. *Dr. F. E. Zantow* was reelected secretary–treasurer. All of the officers are from Oconto.

Pierce–St. Croix

The Pierce–St. Croix County Medical Society met at the Dibbo Hotel in Hudson on October 18. Dr. Jerome A. Hilger of St. Paul, Minnesota, presented an illustrated paper on the recent advancements in the management of patients with diseases of the ear, nose, and throat.

A discussion of the immunization program in Pierce County was led by *Drs. C. W. Horswill* and *R. E. Graber*, both of the State Health Department of Chippewa Falls.

Polk

Meeting at the Paradise Lodge at Balsam Lake as guests of *Dr. M. G. Marra* of Amery, the Polk County Medical Society heard an address by Dr. Thomas J. Edwards, St. Paul, Minnesota. He discussed eye problems of interest to the general practitioner. A round-table discussion followed.

Election of officers was held, and *Dr. F. L. Whitlark* of Amery was named president; *Dr. J. C. Belshe*, St. Croix Falls, vice-president; *Dr. L. J. Weller*, Osceola, secretary–treasurer; and *Dr. W. A. Fischer*, Frederic, censor for three years.

Racine

The Racine County Medical Society met on October 19 at the Rivermoor Country Club, Waterford, for dinner and a business meeting. Forty members were present.

Rock

The regular monthly meeting of the Rock County Medical Society was held on October 25 at the Hotel Hilton in Beloit.

Election of officers was held, and the following now preside: *Dr. F. M. Frechette*, Janesville, president; *Dr. R. H. Gunderson*, Beloit, vice-president; *Dr. E. S. Hartlaub*, Janesville, secretary–treasurer; *Dr. H. E. Kasten*, Beloit, delegate to the State Society; and *Dr. Russell Wilson*, Beloit, member of the board of censors.

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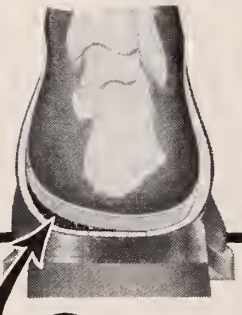

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Sauk

A joint meeting of the Sauk County Medical Society and the Sauk–Juneau County Dental Society was held November 8 at the Warren Hotel in Baraboo. *Dr. Frank Bernard*, professor of plastic surgery at the University of Wisconsin Medical School, Madison, spoke on "Treatment of Injuries of the Face."

Sixteen physicians and eleven dentists were present.

Waupaca

The October meeting of the Waupaca County Medical Society was held at the Elwood Hotel, New London. A Salk vaccine program to include the five through nine-year-old age group was approved.

Winnebago

Dr. Harry Waisman, associate professor at the University of Wisconsin Medical School, addressed the Winnebago County Medical Society at the Elks Club, Oshkosh, November 10. He spoke on recent advancements in pediatrics.

Milwaukee Society of Anesthesiologists

Dr. John M. Beffel, Wauwatosa, spoke to the Milwaukee Society of Anesthesiologists at the Milwaukee Athletic Club, October 10. He discussed the meeting of the World Society of Anesthesiologists which he recently attended at Scheveningen, Holland. Members also participated in a general discussion on hypothermia.

Milwaukee Neuro-Psychiatric Society

The regular meeting of the Milwaukee Neuro-Psychiatric Society was held at the University Club, Milwaukee, on November 16. The scientific session included talks by *Dr. Ernst Schmidhofer*, Milwaukee, on "Some Clinical Considerations of Sleep Hearing"; *Dr. Jules D. Levin*, Milwaukee, on "Traumatic Cerebral Spinal Fluid Fistulae"; and *Dr. G. A. Bacon*, Racine, on "A Multi-Disciplined Approach to the Treatment of Multiple Sclerosis."

Milwaukee Oto-Ophthalmic Society

Members of the Milwaukee Oto-Ophthalmic Society elected new officers at their annual meeting in October. *Dr. D. T. Hughson* was elected president; *Dr. H. V. Morter*, vice-president; and *Dr. E. F. Carl*, secretary.

A scientific program was presented at the November 22 meeting of the society held at the Milwaukee University Club. Dr. Merle Lawrence spoke on "The Significance of Distortion in Hearing," after which a motion picture on ophthalmology was presented.

Milwaukee Academy of Medicine

Lieutenant Commander George W. Hyatt, MC, U.S.N., Bethesda, Maryland, was the guest speaker at the Milwaukee Academy of Medicine meeting on November 15 at the University Club, Milwaukee. He chose as his topic, "The Procurement and Clinical Use of the Stored Homograft."

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Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Earl H. Ninow, M. D.
Paul J. Lawler, M. D.

News Items and Personals

Dr. J. F. Bennett Honored

The Ross Wilcox American Legion Post honored *Dr. J. F. Bennett* of Burlington at its meeting October 20, with a citation for his service to the community. Doctor Bennett has practiced in Burlington for 36 years. He and Mrs. Bennett are moving to California and will make their home in Oakland in order to be near their family.

Doctor Leighton Renamed County Physician

At a recent meeting of the county board of Sheboygan, *Dr. F. A. Leighton* of Sheboygan Falls was re-elected to serve another one-year term as county physician. Doctor Leighton presented the annual report of his office at this meeting.

Dr. Kaare Getz Joins La Crosse Physicians

Dr. Kaare Getz recently joined the staff of the Gundersen Clinic and the La Crosse Lutheran Hospital at La Crosse. Having recently completed a fellowship in dermatology and syphilology at the Mayo Clinic, he will specialize in this field.

Doctor Weber and Family Tour Europe

Dr. Frank Weber, Arcadia, and his wife and daughter left during the week of October 16 for a tour of Europe, making the trip by plane. One of the highlights of their trip included a stop at Siegen, Westphalia, where they visited with Doctor Weber's sister. Also included in the plans was a visit to Doctor Weber's birthplace, Meschede, Westphalia.

Medical Writers' Group Re-elects Dr. Marshall

Dr. Wallace S. Marshall of Two Rivers was re-elected to a third two-year term as a member of the board of directors of the American Medical Writers' Association at its recent annual meeting held in St. Louis, Missouri. Doctor Marshall is the author of *Essentials of Medical Research.*

Health Meet Held at Medford

A Price–Taylor County Health Meet was held in Medford at the Medford Municipal Auditorium, October 27. Guest speakers for the morning session

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included *Dr. E. S. Gordon* and *Dr. H. Kent Tenney*, University of Wisconsin Medical School faculty members. During the afternoon there was a panel discussion on "Special Health Problems," moderated by *Dr. Walther Meyer* of the Medford Clinic.

Doctor Simonson Appointed Chairman of Pediatrics Group

Dr. Lloyd Simonson of Sheboygan has been named as state chairman of the Wisconsin Academy of Pediatrics. Past chairman of this group was *Dr. F. J. Mellencamp* of Milwaukee.

Eleven State Surgeons Inducted Into American College of Surgeons

At the close of the annual meeting of the American College of Surgeons held in Chicago the first week of November, eleven Wisconsin surgeons were inducted as Fellows of the group. Those included were: *Drs. J. P. Docktor, G. W. Hilliard, N. A. Mikolajczak, K. E. Sauter,* and *Carlton Wirthwein,* Milwaukee; *F. P. Nause* and *J. J. Van Driest,* Sheboygan; *D. D. Willson,* Fond du Lac; *J. F. Pember, II,* Janesville; *W. V. Luetke,* Madison; and *J. H. Holman,* Racine.

Rhinelander Physicians Speak at Meeting of Upper Michigan Medical Group

The Warner S. Bump medical group of Rhinelander presented a scientific program for the Gogebic County Medical Society of Michigan, October 27 at the Little Bohemia Lodge at Manitowish Waters. *Dr. George Thuerer* presented a paper on "Fractional Spinal Anesthesia"; *Dr. Marvin Wright* spoke on "Autotransfusion"; *Dr. Thomas M. Haug* discussed "Duodenal Obstruction in the Newborn"; and *Dr. W. S. Bump* presented several cases for diagnosis.

THIRD AND TWELFTH DISTRICTS NEWS

Awards Given Two Madison Physicians

At the Interstate Postgraduate Medical Association meeting held in Milwaukee, November 14–17, special attendance awards were given to *Dr. Erwin R. Schmidt* and *Dr. W. T. Lindsay,* both of Madison. The awards were granted for continuance of medical education by attending 10 or more meetings of the association since 1940.

Dr. J. M. Beffel Visits Europe

Dr. J. M. Beffel, Wauwatosa, recently returned from a tour of Europe. While there, he attended the First World Congress of Anesthesiologists at Scheveningen, Holland.

Doctor Beffel gave up his private practice after World War II to devote his time to the study and practice of anesthesia.

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Jackson Clinic, Madison, Moves to New Building

A staff of 22 doctors and two administrative officers has moved into the new Jackson Clinic at 30 South Henry Street, Madison. A four-story building, the clinic gives the staff the enlarged quarters needed for its various departments and provides room for future expansion of clinic facilities. The new clinic is located next to the Methodist Hospital.

Physicians associated with the clinic are: *Drs. Arnold S. Jackson, L. E. Holmgren, J. R. Steeper,* and *R. H. Jackson, Jr.*, surgery; *H. W. Mahaffey,* orthopedic surgery; Vaughn Demergian, industrial surgery; *A. W. Bryan, H. C. Ashman, R. A. Straughn,* and *J. H. Flinn,* internal medicine; *G. H. Ewell* and *J. J. Mueller,* urology; E. H. Wood, ophthalmology; *J. A. Hurlbut* and *R. B. Ainslie,* otorhinolaryngology; *Addie M. Schwittay* and *L. B. Stevenson,* obstetrics and gynecology; *C. F. Schroeder,* allergy and dermatology; *Margaret Prouty* and *Dorothy H. Oakley,* pediatrics; *Etheldred L. Schafer,* clinical laboratory and pathology; and *W. L. Waskow,* radiology.

Doctor Ganser Heads Diagnostic Center

The State Department of Public Welfare announced October 23 that *Dr. Leonard J. Ganser* has been promoted to superintendent of the Wisconsin Diagnostic Center in Madison. Doctor Ganser has been with the staff of the center since July of 1953.

Doctor Tenney Speaks to P.T.A.

Dr. H. Kent Tenney, Madison pediatrician, was the guest speaker on a panel at the Lincoln school P.T.A. meeting on October 20. His talk was centered about the treatment and handling of young children with a view toward the development of good social and emotional adjustment.

Dr. E. C. Welsh Discusses Back Injuries

At a dinner meeting of the industrial division of the Twin City Safety Council at Germania Hall, Menasha, November 16, *Dr. E. C. Welsh* of Milwaukee discussed "Material Handling and Back Trouble," which is considered one of the major industrial injury problems today. Doctor Welsh is director of the department of physical medicine and rehabilitation at Columbia and St. Luke's hospitals, Milwaukee.

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INTENSIVE POSTGRADUATE COURSES

STARTING DATES—WINTER, 1956

SURGERY—Surgical Technic, Two Weeks, January 23, February 6
Surgical Anatomy & Clinical Surgery, Two Weeks, March 5
Surgery of Colon & Rectum, One Week, February 27, April 9
General Surgery, One Week, February 13; Two Weeks, April 23
Basic Principles in General Surgery, Two Weeks, April 9
Gallbladder Surgery, Ten Hours, April 9
Fractures & Traumatic Surgery, Two Weeks, March 12
GYNECOLOGY—Office & Operative Gynecology, Two Weeks, February 13, March 12
Vaginal Approach to Pelvic Surgery, One Week, February 6, March 5
OBSTETRICS—General & Surgical Obstetrics, Two Weeks, February 27, March 26
MEDICINE—Internal Medicine, Two Weeks, May 7
Electrocardiography & Heart Disease, Two-Week Basic Course, March 12
Gastroscopy, Forty-Hour Basic Course, March 19
Dermatology, Two Weeks, May 7
RADIOLOGY—Diagnostic X-Ray, Two Weeks, February 6
Clinical Use of Radioactive Iodine, One Week, April 2
Clinical Uses of Radioisotopes, Two Weeks, May 7
PEDIATRICS—Intensive Review Course, Two Weeks, May 14
Neurological Diseases; Cerebral Palsy, Two Weeks, June 18
UROLOGY—Two-Week Course, April 16
Cystoscopy, Ten Days, by appointment

Teaching Faculty—Attending Staff of Cook County Hospital
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Doctor Foseid Joins Jackson Clinic

Dr. Oscar F. Foseid recently joined the general surgery staff of the Jackson Clinic in Madison. A native of Madison, Doctor Foseid has recently completed a four-year residency at the University Hospitals in general and chest surgery. He completed an additional year in cancer research projects and as assistant director of the University Hospitals' cancer tumor clinic.

H. E. Kastens Return from Trip Abroad

Dr. and Mrs. *H. E. Kasten* returned to their home in Beloit on October 2 after a seven-week trip to Europe and the Near East.

They visited Rome, Cairo, Old and New Jerusalem, Tel-Aviv, Istanbul (during the September anti-Greek riots), Athens, Munich, Oberammergau, and Vienna, where they attended the World Assembly of Medicine. While in Vienna, they stopped off at the house they had lived in in 1931 when Doctor Kasten was taking postgraduate work at the university there. This house, incidentally, was once occupied by Beethoven.

SOCIETY RECORDS

New Members

J. R. Healy, 110 East Main Street, Madison.
J. S. Tschetter, Whitehall.
D. O. Price, 1922 University Avenue, Madison.
J. A. Rennebohm, 5001 Monona Drive, Madison.
H. D. Baernstein, Jr., 810 Main Street, Racine.
R. W. Cranston, 5706 Bittersweet Place, Madison.
Jay P. Keepman, 621 South Park Street, Madison.
L. D. Milliken, Jr., 625 57th Street, Kenosha.
H. F. Ibach, 1845 North Fourth, Milwaukee.
R. O. Barnes, 1545 South Layton Boulevard, Milwaukee.
D. W. Barrow, 8700 West Wisconsin Avenue, Milwaukee.
A. S. Lanier, 405A Milwaukee, Kewaunee.
Patricia A. F. Lanier, 405A Milwaukee, Kewaunee.
K. L. Zucker, 103 South Madison Street, Green Bay.
Evelyn D. Lipp, 4150 Hiawatha Drive, Madison.
C. R. MacLean, Memorial Hospital, Manitowoc.

Changes of Address

D. A. Cofrin, Green Bay, to 740 N. W. 20th Street, Gainesville, Florida.
J. F. Bennett, Burlington, to 3675 Delmont Avenue, Oakland 5, California.
R. T. Cooney, De Forest, to 310 West Conant Street, Portage.
R. F. Gosin,** Green Bay, to 557 Richmond Avenue, Buffalo, New York.
Salvatore Megna, Milwaukee, to 2906 East Third Street, Tucson, Arizona.

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George Light, Milwaukee, to Route 3, Box 506, Highway K, Markesan.

J. W. Truitt, Milwaukee, to 1330 East 32nd Place, Tulsa, Oklahoma.

Stephen Cahana, Milwaukee, to 1201 Westwood Boulevard, Los Angeles 24, California.

J. P. Pauly, Long Island, New York, to 212 South 11th Street, La Crosse.

R. W. Puckett, Monroe, to 540 West Huntington Drive, Arcadia, California.

J. C. Fox, Hingham, Massachusetts, to 212 South 11th Street, La Crosse.

J. D. Spankus,** Charleston AFB, South Carolina, to 746th TRP. SQ. (M) FPO 127, Seattle, Washington.

W. G. Bear, Monroe, to 545 Tangerine Avenue, St. Petersburg, Florida.

H. S. Ashe, Mercer, to 210 Suffolk Street, Ironwood, Michigan.

D. S. Arvold, Milwaukee, to Cantwell–Peterson Clinic, Shawano.

J. L. Teresi, Ft. Bragg, North Carolina, to 2141 South 88th Street, Milwaukee.

T. C. Lipscomb, Aberdeen, Maryland, to Milwaukee Hospital, Milwaukee.

W. J. Schutz, Shawano, to 257 North Madison Street, Lancaster.

W. C. Verbrick, Little Chute, to 701 Washington Avenue, S. E., Minneapolis, Minnesota.

R. D. Bragman,** Madison, to Tripler Army Hospital, Box 163, APO 438, San Francisco, California.

G. J. Peterson, Beaver Dam, to 53 Bloomfield Terrace, Pontiac, Michigan.

** Military Service.

DEATHS

Dr. Joseph Lettenberger, 80 years of age, died at his home in Milwaukee on November 1 following a short illness.

Born on November 23, 1874, in St. Nazianz, Doctor Lettenberger received his medical degree from the Wisconsin College of Physicians and Surgeons, Milwaukee, in 1896. He practiced at Arcadia until 1907, when he moved to Milwaukee and conducted his practice on the south side.

Doctor Lettenberger's special interest was in the field of internal medicine. He was a Fellow of the American College of Physicians and a Diplomate of the American Board of Internal Medicine. During his years in Arcadia he had served as president of the Trempealeau County Medical Society. He had been assistant professor of internal medicine at the Marquette University School of Medicine for 28 years.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Doctor Lettenberger served in the Navy as a lieutenant commander in 1918.

He is survived by his widow, Adele, and a daughter, Mrs. Marion Johnson, of Bronxville, New York.

Dr. Arthur Charles Kissling, Sr., 72, died on November 7 at a Milwaukee hospital following a short illness.

He was born on November 9, 1882, in Germany, where his father, Dr. Charles L. Kissling, was studying at the time. He was graduated from Johns Hopkins University School of Medicine in Baltimore, Maryland, in 1911. Before moving to Milwaukee, he served a year's internship at Jefferson Hospital, Roanoke, Virginia. He took postgraduate work at Rush Medical College in Chicago; his specialty was in the field of eye, ear, nose, and throat.

A son, Dr. Arthur C., Jr., now practices in Milwaukee.

Doctor Kissling was a former member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. He was a member of the Milwaukee Academy of Medicine and the American Oto-Ophthalmic Society.

Survivors besides his son include a daughter, Mrs. Curtis Wemple of Shorewood, and a sister, Mrs. Hugo A. Schlick, Milwaukee.

Dr. George E. Crosley, who had practiced medicine in Milton since 1909, died at a Madison hospital on November 2. He was 80 years of age.

In addition to his private practice at Milton, Doctor Crosley had served as medical director of the Burdick Corporation of that community for the past 28 years.

Graduating from the Chicago Homeopathic Medical College in 1897, he began his practice in Algonquin, Illinois, where he remained for two and a half years. During this time he was an instructor at a medical college. In 1899 he moved to Albion, and he practiced there until his move to Milton in 1909.

Doctor Crosley was a member of the Rock County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his widow; two sisters, Mrs. Charles Michel of Marion, Iowa; and Mrs. Pearl Sheldon of Albion.

INTERNATIONAL ACADEMY OF PROCTOLOGY 8TH ANNUAL TEACHING SEMINAR

Dates: April 23–26, 1956

Place: The Drake, Chicago

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

against ROUNDWORMS

"Ninety per cent of the children passed all of their ascarides . . ."

Brown, H. W.: J. Pediat. 45:419, 1954.

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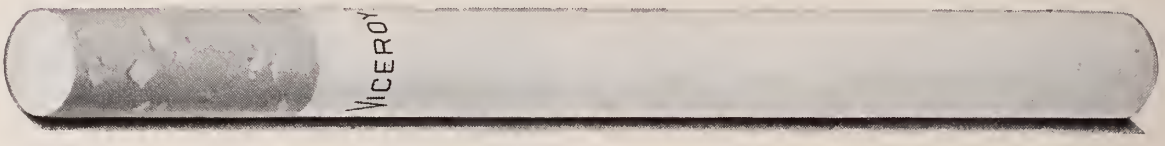

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POLIO AHEAD

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Gentlemen:

The polio case rate in Wisconsin in 1955 was the second highest in the nation—topped only in Massachusetts. The Wisconsin rate was over four times as high as it was in the previous year (1954) and about 130% higher than the average of the previous five years.

To help Wisconsin meet this truly epidemic situation, the National Foundation for Infantile Paralysis gave the following important services (in the first ten months of the year):

Supplied 1,639,960 cc. (approximately $1,500,000 worth) of gamma globulin to provide temporary protection against paralytic polio;

Supplied emergency aid in dollars—in the amount of $200,275—from national headquarters to 18 local chapters to pay for care of polio patients;

Sent shipments of emergency equipment; namely, 95 tank respirators, 9 chest respirators, 46 hot pack machines, and 20 rocking beds;

Arranged for the recruitment of six physical therapists, nine nurses, and one medical social worker to work in Wisconsin hospitals;

Shipped 216,000 cc. of Salk vaccine to initiate the state's program of vaccination against paralytic polio.

Will there be polio problems in Wisconsin in 1956? Unquestionably yes. Some will be the aftermath of the 1955 epidemic or attacks in earlier years. Others will be new cases.

The Salk vaccine is a major weapon against paralytic poliomyelitis, but it has not yet won the war against this disease.

Continuing cooperation of physicians must be had both in administering the vaccine and in caring for patients already paralyzed and those who *will be* paralyzed in spite of the vaccine. The Salk vaccine is not 100% effective; and it will take considerable time yet — perhaps years — before all individuals most susceptible to paralytic poliomyelitis can be fully immunized against it.

The results already reported from the use of the vaccine are most encouraging, but they must not be allowed to blind the eye of the medical profession

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to the road that still lies ahead. There remains a great need for additional research to improve the Salk vaccine, to determine the duration of immunity it effects (and conversely to determine when there is need for "booster shots"), and to provide the best possible treatment for patients already or yet to be involved with paralytic poliomyelitis. There is also a vast need for the professional education of young men and women who will contribute to the necessary research and help give the needed treatment.

The record of the National Foundation for Infantile Paralysis in Wisconsin should help orient physicians to the many services it has rendered patients and the profession:

Over $5,000,000 has been spent in Wisconsin by local chapters for the care of polio patients.

A total of 131 National Foundation scholarships and fellowships has been awarded to Wisconsin residents.

Professional education grants, in addition, to Wisconsin institutions, have totaled nearly $130,000.

A considerable amount of research in virology and the treatment and aftercare of poliomyelitis has been conducted in Wisconsin. Toward this research the Foundation has contributed $199,000.

Wisconsin institutions currently having grants are the University of Wisconsin and Marquette University.

Very truly yours,
/s/ Hart E. Van Riper, M. D.
Medical Director, The National Foundation for Infantile Paralysis, Inc.

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The Wisconsin Medical Journal

OWNED *and* PUBLISHED *by the* STATE MEDICAL SOCIETY *of* WISCONSIN

A Monthly Journal of Medicine and Surgery

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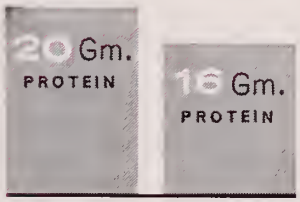

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1. Jeans, P. C., in A.M.A. Handbook of Nutrition, Philadelphia, Blakiston, 1951, pp. 275-298. 2. Stare, F. J., and Davidson, C. S., in The Proteins, American Medical Association, 1945.

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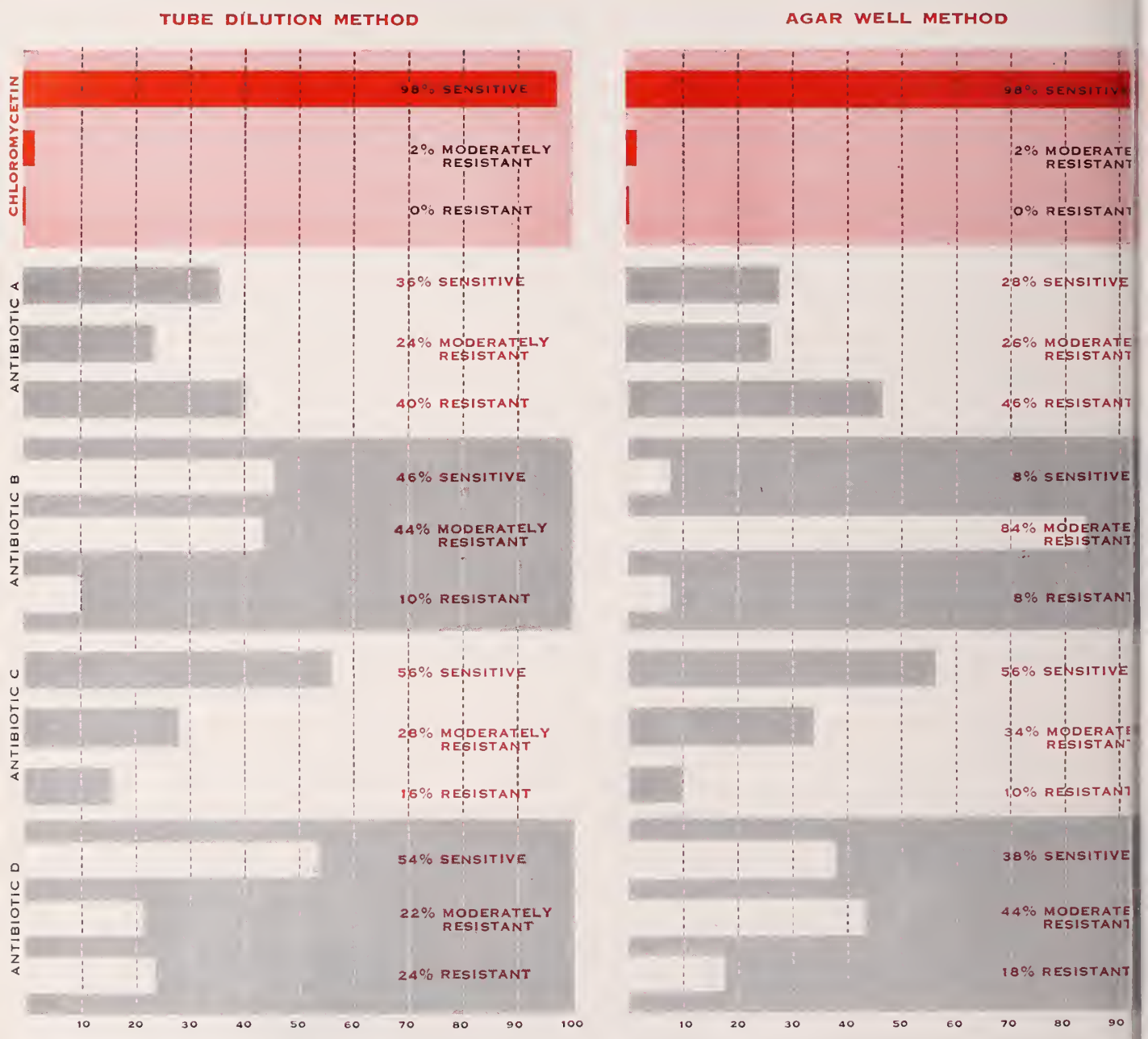

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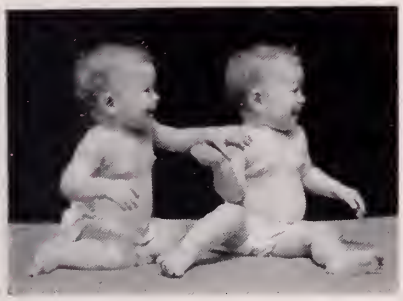

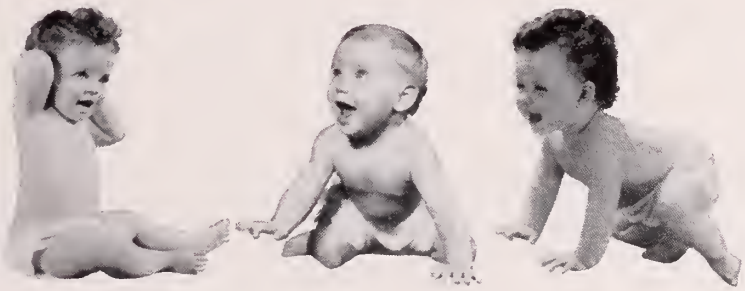

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(1) Jeans, P. C., in A. M. A. Handbook of Nutrition, ed. 2, Philadelphia, Blakiston, 1951, pp. 275-278.

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